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No. _____

In The

Supreme Court of the United States

NEVADACARE, INC.,

Petitioner,

v.

RUBY SIMKINS and M & K ENTERPRISES,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

1.

The opinion below presents an important question of national law: Does an insurer's use of medical terminology to limit its risk as provided for by the HMO Act of 1973 automatically violate the requirement under ERISA to provide a plan description that is easily understood by the average person?

2.

The opinion below perpetuates the split among circuits concerning the use of the *contra proferentem* rule as a matter of ERISA federal common law. To resolve this split, the Court should determine if this rule is applicable to insurance plans governed by ERISA, and, if so, what is its scope?

PARTIES BELOW

Petitioner NevadaCare, Inc. appeared in the court below as defendant-appellee. Respondents Ruby Simkins and M & K Enterprises appeared as plaintiffs-appellants.

RULE 29.6 LISTING

The parent company of NevadaCare, Inc. is h/mx Health Management Solutions, Inc., a privately held Arizona corporation. NevadaCare, Inc. has no affiliates or subsidiaries.

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PETITION FOR WRIT OF CERTIORARI

NevadaCare, Inc. ("NevadaCare") respectfully prays that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Ninth Circuit, entered in this proceeding on October 31, 2000, to settle an important question of federal law that has not yet been addressed by this Court and to resolve a conflict among the Circuits on an important issue presented herein.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Ninth Circuit that gives rise to this petition is published as *Simkins v. NevadaCare, Inc.*, 229 F.3d 729 (9th Cir. 2000). The opinion is reprinted in the Appendix ("App.") at 1-16.

The Ninth Circuit had previously rendered an opinion on October 3, 2000 which was amended by the above-cited opinion on October 31, 2000. See App. at 17-31.

The Ninth Circuit decision is a reversal of the unreported decision of the United States District Court for the District of Nevada, D.C. No. CV-98-01133-DAE(RJJ). See App. at 33-51.

JURISDICTION

The United States District Court for the District of Nevada granted NevadaCare's Motion for Summary Judgment on July 20, 1999. On October 3, 2000, the

United States Court of Appeals for the Ninth Circuit entered its order and opinion, reversing the decision of the District Court, and mandating that Simkins' Motion for Summary Judgment be granted. Thereafter, on October 31, 2000, the Ninth Circuit Court amended its decision. Pursuant to Supreme Court Rule 13.1, this petition has been filed within 90 days of the entry of the amended decision. The issues at bar are federal questions, as all issues stem from a group employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et seq.*

The jurisdiction of the Court is invoked pursuant to 28 U.S.C. § 1254(1).

STATUTE INVOLVED IN THE CASE

The constitutional provisions, treaties, statutes, ordinances and regulations involved in this case are as follows:

29 U.S.C. § 1022

§ 1022. Summary plan description

> (a) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in section 1024(b) of this title. The summary plan description shall include the information described in subsection (b) of this section, shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the

plan. A summary of any material modification in the terms of the plan and any change in the information required under subsection (b) of this section shall be written in a manner calculated to be understood by the average plan participant and shall be furnished in accordance with section 1024(b)(1) of this title.

(b) The summary plan description shall contain the following information: The name and type of administration of the plan; in the case of a group health plan (as defined in section 1191b(a)(1) of this title), whether a health insurance issuer (as defined in section 1191b(b)(2) of this title) is responsible for the financing or administration (including payment of claims) of the plan and (if so) the name and address of such issuer; the name and address of the person designated as agent for the service of legal process, if such person is not the administrator; the name and address of the administrator; names, titles, and addresses of any trustee or trustees (if they are persons different from the administrator); a description of the relevant provisions of any applicable collective bargaining agreement; the plan's requirements respecting eligibility for participation and benefits; a description of the provisions providing for nonforfeitable pension benefits; circumstances which may result in disqualification, ineligibility, or denial or loss of benefits; the source of financing of the plan and the identity of any organization through which benefits are provided; the date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis; the procedures to be followed in presenting claims for benefits under the plan including the office at the Department of Labor through

> which participants and beneficiaries may seek assistance or information regarding their rights under this chapter and the Health Insurance Portability and Accountability Act of 1996 with respect to health benefits that are offered through a group health plan (as defined in section 1191b(a)(1) of this title) and the remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 1133 of this title).

STATEMENT OF THE CASE

Factual Background

NevadaCare is a licensed health maintenance organization ("HMO") in the state of Nevada; the company was granted its certificate of authority in September 1995 by the Nevada Division of Insurance.

In 1996, Ruby Simkins was diagnosed with breast cancer and underwent a lumpectomy followed by radiation therapy in October 1996. After several return visits and tests, Mrs. Simkins' cancer had not returned as of October 1997.

Beginning January 1, 1998, M&K Enterprises ("M&K") offered health care benefits to its employees through NevadaCare, as part of M&K's employee welfare benefit plan. Each subscriber and enrolled dependent was provided an Evidence of Coverage (EOC) booklet describing the covered benefits. App. 52-109. Although an employee of M&K, Ruby Simkins was enrolled in the plan through her husband, Louis Simkins, the owner of M&K.

In February 1998, tests revealed that Mrs. Simkins' cancer had metastasized to her lungs and liver. In March 1998, Mrs. Simkins' doctors in Las Vegas requested authorization from NevadaCare for a referral to Dr. John Glaspy at UCLA to determine her candidacy for bone marrow transplant high dose chemotherapy.

On April 3, 1998, UCLA Medical Center's Bone Marrow Transplant Service requested written medical necessity authorization from NevadaCare for "high dose chemotherapy with autogolous [sic] peripheral blood stem cell +/- bone marrow support." App. 7. On April 30, 1998, NevadaCare denied Mrs. Simkins' request for coverage of the autologous bone marrow transplant; the basis for the denial was the plan's exclusion of all tissue transplant procedures except allogenic bone marrow transplants. App. 8. The denial was not related to medical necessity nor based on an exclusion for experimental treatments.[1]

---

[1] Subsequent to NevadaCare's denial, the treatment received by Mrs. Simkins at UCLA has been determined to be ineffective in treating breast cancer. Edward Stadtmauer et al., *Conventional-Dose Chemotherapy Compared with High-Dose Chemotherapy plus Autologous Hematopoietic Stem-Cell Transplantation for Metastatic Breast Cancer*, 342 NEW ENG. J. MED. 15 (April 13, 2000) ("high-dose chemotherapy plus autologous stem-cell transplantation . . . does not improve survival in women with metastatic breast cancer.") See also, Marc E. Lippman, Editorial, *High-Dose Chemotherapy plus Autologous Bone Marrow Transplantation for Metastatic Breast Cancer*, 342 NEW ENG. J. MED. 15 (April 13, 2000)("several other studies of this issue have also been negative").

Under the benefit provisions of the EOC, only certain "Transplant Services" are covered. The EOC provides as follows:

> R. Transplant Services
>
> Coverage is provided for the Medically Necessary services required for human tissue and organ transplants, for the treatment of non-occupational disease or injury. All transplant related services must be pre-authorized by the NevadaCare Medical Director.
>
> 1. Organ transplants for heart, kidney, cornea, and liver. Liver transplant limited to that required as a result of biliary artresia only.
>
> 2. Tissue transplant coverage is limited to allogenic bone marrow only.
>
> 3. Coverage is provided for the necessary Hospital, surgical, laboratory, and x-ray expenses incurred by a donor for an authorized transplant to a Member, unless the donor has coverage for such expenses.

App. 6 and App. 84-85. The exclusionary provision in the EOC contains the same limitation as found under the benefit provision. This provision is as follows:

> 31. We will cover services for covered organ transplant expenses, as defined below, incurred by a Member for an organ transplant approved by Us at a facility approved by Us, subject to those conditions and limitations described below. Transplant means pre-transplant, transplant and post-discharge services, and treatment of complications after transplantation. We will cover only services, care and treatment received

> for or in connection with the approved transplantation of the following human organs:
>
> 1. Heart, Kidney, Cornea, and Liver. Liver transplant is limited to that required as a result of biliary atresia only.
>
> 2. Tissue transplant coverage is limited to allogenic bone marrow only.
>
> For a transplant procedure to be considered approved, prior approval from the company's Medical Director is required in advance of the procedure.

App. 6 and App. 91. There is also a catchall exclusion in the plan description for "Any services or supplies not specifically listed in this Evidence of Coverage as covered benefits, services or supplies." App. 6 and App. 91.

Mrs. Simkins underwent the high dose chemotherapy/stem cell transplant procedure ("HDC/PSCR") in June to July 1998. HDC/PSCR is a complex, multi-step procedure. First, the production of stem cells and their migration from the bone marrow to the blood stream is stimulated with drugs. Stem cells are young cells found in bone marrow which can mature into the different types of cells which circulate in the blood. A catheter is surgically implanted in a large vein under the collar bone. Through the catheter, blood is withdrawn over the course of several days. Stem cells are harvested from the blood and frozen; the blood is returned to the patient's body. At that point, the patient receives several days of high dose chemotherapy, up to hundreds of times the normal dosages. These high doses kill off the cancer cells, but also kill healthy cells, leaving the patient's immune system in a critical state. Finally, to rescue the patient's immune

system, the previously collected stem cells are reinfused into the patient's blood stream, with the expectation that they will migrate back into the bone marrow and mature into white blood cells.

Procedural History

In August 1998, Mrs. Simkins and M&K filed a complaint against NevadaCare in the United States District Court for the District of Nevada to recover the cost of the HDC/PSCR treatment. The insurance plan in question was an employee welfare benefit plan governed by ERISA, 29 U.S.C. § 1001 *et seq.* Because the causes of action alleged by the Plaintiff were related to ERISA, the District Court had subject matter jurisdiction.

The court heard oral argument on crossmotions for summary judgment on June 22, 1999 and issued its Order on July 20, 1999. Judge Ezra ruled in NevadaCare's favor on all counts, granting summary judgment. The judgment appears at App. 32. Mrs. Simkins appealed the decision to the Ninth Circuit. Oral argument was held on June 14, 2000; a written opinion was issued on October 3, 2000 and amended October 31, 2000.

The Ninth Circuit's Opinion

The Ninth Circuit panel reversed the district court's decision to grant summary judgment for NevadaCare and ordered that summary judgment be entered for plaintiff. The Court held that the district court should have considered whether a person of average intelligence would construe "tissue transplant" to encompass the HDC/

PSCR procedure, which is medically classified as a tissue transplant. App. 12. The Court reasoned that since the average person would consider HDC/PSCR to be a blood transfusion, and the EOC discusses blood transfusions separately from tissue transplants, the EOC was ambiguous. Moreover, the Court held that, because one could reasonably read the plan description's blood transfusion provision and the plan description's chemotherapy provision to include HDC/PSCR, NevadaCare could not deny coverage. Applying the *contra proferentem* rule, the Court ruled that any jury hearing this case would be required to interpret any ambiguity in the favor of the insured, and, as such, directed the District Court to enter summary judgment on behalf of the plaintiff.

ARGUMENT IN SUPPORT OF PETITION

Question One

The opinion below presents an important question of national law: Does an insurer's use of medical terminology to limit its risk as provided for by the HMO Act of 1973 automatically violate the requirement under ERISA to provide a plan description that is easily understood by the average person?

An HMO balances its mandate to provide low cost health care by limiting its risks with the rights of ERISA plan participants to a concise, easy-to-understand plan description. The Ninth Circuit's decision in *Simkins* creates a conflict in the operation of two federal acts of equal dignity, the Health Maintenance Organization Act of 1973, 87 Stat. 914, 42 U.S.C. § 300e (as amended) ("the

HMO Act"), and the Employees Retirement Income Security Act of 1974, 88 Stat. 832, 29 U.S.C. §§ 1001 et seq. (as amended) ("ERISA").

In *Pegram v. Herdrich*, 120 S.Ct. 2143 (2000), this Court made it clear that Congress, in passing the HMO Act, approved of HMOs in order to provide lower-cost health care to the public. Faced with skyrocketing medical expenditures and a lack of medical care in rural areas and the inner cities, Congress passed the HMO Act to encourage the formation of HMOs to provide low-cost, comprehensive and widely-available health care. S. REP. NO. 93-120, at 1 (April 27, 1973). President Nixon stated, "I believe that [HMOs] ought to be everywhere available so that families will have a choice" between HMOs and fee-for-service health care. *Id.*

However, the HMO Act alone does not govern employer-based HMO plans. The rules of ERISA, which require a plan description to be "written in a manner calculated to be understood by the average plan participant," also apply. 29 U.S.C. § 1022(a). Although these statutes do not appear to conflict on their face, the Ninth Circuit's holding in *Simkins* diminishes the ability of HMO plans governed by ERISA to provide low cost medical insurance.

Medical Terms and Ambiguity Per Se

Simkins is clear that general descriptions such as "blood transfusion" and "tissue transplant" are ambiguous terms. Or, more precisely, that the insured's subjective understanding of those descriptions (or complete lack of understanding) creates that ambiguity. However,

this Court has stated that, "[i]n practical terms, . . . eligibility decisions cannot be untangled from physicians' judgments. . . . " *Pegram*, 120 S.Ct. 2154. Any medical doctor would consider HDC/PSCR a tissue transplant. That is clear on the record below. However, the *Simkins* court found that the use of the term "tissue transplant" in the plan's EOC was ambiguous. The Court in *Simkins* reasoned that because the plaintiff did not understand the procedure of HDC/PSCR to be a tissue transplant, or that stem cells are "tissue," then the insurer's classification, as such, was ambiguous.

The question remains, is a medical term used to describe benefits or exclusions in a summary plan description governed by ERISA ambiguous per se? Although there is no direct split of the circuits on this issue, it is a great source of uncertainty that needs to be resolved by the Supreme Court. Different circuits have approached similar problems using different methods. In *Masella v. Blue Cross Blue Shield of Ct.*, 936 F.2d 98 (2d Cir. 1991), the Second Circuit found reasonable a jury determination that Temporomandibular Joint condition ("TMJ") was a medical rather than dental condition. Although the Second Circuit found for the insured, its approach was much different than the Ninth Circuit's in *Simkins*. In *Masella*, the court acknowledged that if TMJ was in fact a "dental condition," it would not be covered by the policy. Moreover, the Circuit Court approved of the district court's allowance of medical expert testimony on whether TMJ was a medical or dental condition. Thus, rather than make an ad hoc determination, ignoring all medical understanding of a procedure, it determined that

the condition fell into a covered category after considering medical evidence. This is consistent with the Second Circuit's definition of ambiguity as a term which is. "capable of more than one meaning when viewed objectively by a reasonably intelligent person in the context of the entire agreement." *Hoffman v. Empire Blue Cross Blue Shield*, 1999 WL 782518 (S.D.N.Y. 1999).

The Seventh Circuit has held that contract language is ambiguous if it is subject to more than one interpretation and that terms in a policy are interpreted in an ordinary and popular sense. *Auto Owners Ins. Co. v. L.P. Cavett Co.*, 882 F.2d 1111, 1113 (7th Cir. 1989); *Hammond v. Fidelity & Guar. Life Ins. Co.*, 965 F.2d 428, 430 (7th Cir. 1992) (will not create ambiguity where none exists). However, that circuit has limited applying such rules to situations where ambiguity truly exists. In *Phillips v. Lincoln Nat'l Life Ins. Co.*, 978 F.2d 308 (7th Cir. 1993), the court held:

> the rule that ambiguities must be resolved against insurers can only be invoked when there exists a genuine (meaning, substantial) uncertainty, not resolvable by other means, and the insured's proposed reading must be reasonable. . . . Rules of interpretation are tiebreakers, even when the words being interpreted appear in insurance policies. *Phillips* at 313.

Likewise, the Tenth Circuit has found that where a court can ascertain the plain meaning of a term, there is no reason to search for ambiguity. *McGee v. Equicor-Equitable HCA Corp.*, 953 F.2d 1192 (10th Cir. 1992) (holding that "bodily injury" was not an ambiguous term under

the policy); *see also Golden Rule Ins. Co. v. Atallah*, 45 F.3d 512 (1st Cir. 1995) (the First Circuit prior to finding that a pre-existing condition clause was ambiguous held that a "court may not rewrite the contract where the language employed is free of doubt"). Further, the Sixth Circuit has held that a court is not free to apply a layman's prognosis of a situation when a term is used by a medical expert in the context of a professional opinion. *Tolley v. Commercial Life Ins. Co.*, 14 F.3d 602 (unpublished), 1993 WL 524284 (6th Cir. 1993). This can be compared with the Eighth Circuit's holding that a court must concentrate on a lay-person's understanding of a condition. *Brewer v. Lincoln Nat'l Life Ins. Co.*, 921 F.2d 150 (8th Cir. 1990).

The Embodiment of the Conflict

To avoid what the Ninth Circuit perceives as ambiguity, an HMO would need to list each medical procedure or treatment by name that is covered or excluded by the plan description. Since there is no generic way to describe a complex procedure such as HDC/PSCR, the only option would be to list this and all other procedures by name. Indeed, the *Simkins* opinion advises HMOs to do just that:

> If NevadaCare wishes to exclude coverage of a procedure such as HDC/PSCR from its insurance plans, it should do so conspicuously and unambiguously so a reasonable insured can determine this fact by looking at her policy.[2]

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[2] The Ninth Circuit appears to presume that Mrs. Simkins formed her own opinion of coverage prior to the denial of her request for preauthorization in April 1998. Preauthorization is recognized as one way an HMO endeavors to limit its risk and

The Ninth Circuit's directive embodies the conflict between the HMO Act and ERISA. Compliance with the above-cited passage would require an HMO not only to create a longer and more burdensome EOC, but also to research each and every medical procedure that exists or may possibly exist over the life of the coverage. There are more than 94,000 specific procedures identified by the Physicians Current Procedural Terminology (CPT) as published by the American Medical Association.[3] This is

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lower the cost of health care. *Pegram*, 120 S.Ct. at 2149 (precertification, utilization review and coverage determinations are among the "cost-controlling measures" used by HMOs "like other risk-bearing organizations"). However, NevadaCare specifically advised Mrs. Simkins of the policy provision invoked by her doctor's request. And, at the time she enrolled in the plan, Mrs. Simkins did not know that her cancer would return or that she would be recommended for HDC/PSCR.

[3] "CPT is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. The purpose of the terminology is to provide a uniform language that will accurately describe medical, surgical, and diagnostic services, and will thereby provide an effective means for reliable nationwide communication among physicians, patients, and third parties. . . . CPT is the most widely accepted nomenclature for the reporting of physician procedures and services under government and private health insurance programs." Foreward, AMERICAN MEDICAL ASSOCIATION, CPT 2000 (1999) at iii. CPT codes were developed by the Health Care Financing Administration (HCFA) to assist in reimbursement to providers by Medicare. Many managed care and other insurance companies also base their reimbursements on CPT. In the early 1970s, HCFA asked the American Medical Association to determine appropriate definitions for the codes. A list of the codes (without descriptions) is available at http://otpt.ups.edu/health_policy/CPT codes.html.

a costly exercise that would result in a rise in the cost of insurance, contrary to the legislative purpose of the HMO Act.

The Ninth Circuit's directive also appears to violate ERISA's requirement for an easily understood plan: if the term "tissue transplant" is not understood by an ordinary person, how can the acronym "HDC/PSCR" be easily grasped? State insurance commissioners, employers, and insureds themselves will be left with a long list of medical procedures and treatments in the plan descriptions. This is in contrast with the purpose of 29 U.S.C. § 1022, which is to give beneficiaries a short statement of their benefits, calculated to explain the coverage. Insurers should not be required to anticipate every possible contingency that might affect an insured's status. *Estate of Becker v. Eastman Kodak Company*, 120 F.3d 5 (2d Cir. 1997); *Lorenzen v. Employees Retirement Plan of the Sperry & Hutchinson Co., Inc.*, 896 F.2d 228 (7th Cir. 1990). If insurers were required to write summaries in such a way, the summaries would be "choked with detail and hopelessly confusing." *Lorenzen* at 235. For this reason, the scheme required by *Simkins*, while attempting to resolve a plan description in favor of an insured, is adverse to the interests of all parties in an insurance contract, including the insured. As stated by the Seventh Circuit, "clarity and completeness are competing goods." *Id.*

Even if NevadaCare crafted its EOC in the manner recommended by the Ninth Circuit, there is no guarantee that a court would uphold the limitation. In *Bailey v. Blue Cross & Blue Shield of Virginia*, 67 F.3d 53 (4th Cir. 1995), *cert. denied*, 516 U.S. 1159, 116 S.Ct. 1043, 134 L.Ed.2d 190

(1996), the ERISA plan documents contained the following exclusion: "Autologous bone marrow transplants or other forms of stem cell rescue (in which the patient is the donor) with high dose chemotherapy are not covered." *Bailey*, 67 F.3d at 55. However, elsewhere, the policy covered chemotherapy. The Fourth Circuit determined that created an ambiguity and found "it is reasonable to conclude that the policy exclusion covers only the distinct PSCR." *Id.* at 57-58. Thus, the district court's ruling prohibiting the insurer from denying coverage for the HDC was proper "as a matter of law." *Id.* at 58.[4]

The Result: Unbundling

Since the EOC at issue covers both "blood transfusions" and "chemotherapy" the Ninth Circuit reasoned that "[i]f both steps of HDC/PSCR are covered separately, the average person would find it highly unlikely that they would not be covered when performed together." App. 14. By breaking down HDC/PSCR into two of its many component parts, and then finding that those components are covered, thus the entire procedure is covered, the Ninth Circuit is sanctioning providers and

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[4] However, "Insurers need to be aware that if HDC-ABMT is specifically excluded for breast cancer, a court might find that, because it is not excluded for a different type of cancer, it must be covered." Judith C. Broston, *The Conflict of Interest Standard in ERISA Cases: Can It be Avoided in the Denial of High Dose Chemotherapy Treatment for Breast Cancer?*, 3 DePaul J. Health Care L. 1 (Fall 1999).

insureds to engage in the practice of "unbundling" in ERISA plans.[5]

"Unbundling occurs when a provider bills both for a 'major' and a 'minor' procedure on the same day of service." OFFICE OF INSPECTOR GENERAL, REPORT NO. 09-97-200-04-431, MEDICAL PROVIDERS OVERBILL FECA MILLIONS EACH YEAR (Sept. 29, 1997) at Exhibit II, p. 1. Providers use unbundling in an effort to receive payment for components which are covered, whereas the entire procedure may not be, or to receive higher payments. Under the CPT coding system discussed above, the "minor" procedure is considered a component of the "major" procedure and should not be billed separately.[6]

The Office of the Inspector General considers the unbundling of charges to be a fraudulent act under the

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[5] It is medically unadvisable, if not impossible, to receive HDC as a stand-alone procedure. As both lower courts acknowledge, HDC kills not only cancer cells, but healthy cells as well (App. 7) and would "prove fatal" without "rescue." App. 37.

[6] In the instant case, Mrs. Simkins' procedure was billed to NevadaCare using the CPT code 38241: "Bone marrow or blood-derived peripheral stem cell transplantation; autologous," AMERICAN MEDICAL ASSOCIATION, CPT 2000 (1999) at 158, and was not broken down into various components for which there are individual codes, such as 38231 (Blood-derived peripheral stem cell harvesting for transplantation), 96400-96549 (Chemotherapy administration); 86890 (Autologous blood or component, collection processing and storage); 36215 (Selective catheter placement, aterial system); 88240 (Cryopreservation, freezing and storage of cells); 88241 (Thawing and expansion of frozen cells).

Medicare Program[7] and providers may be suspended from the program, or even terminated, for unbundling. *Midwest Family Clinic, Inc. v. Shalala*, 998 F. Supp. 763 (E.D. Mich. 1998) (denying preliminary injunction to lift suspension of Medicare payments where HCFA had "reliable information" that provider had been unbundling diagnostic tests by submitting claims on two different dates when service was rendered on one date).

Medicare considers all of the services necessary to accomplish a given procedure to be included in the description of that procedure as defined by CPT. Ancillary services necessary to accomplish the procedure are considered included, although independent CPT codes may exist for the ancillary services. MEDICARE PART B REFERENCE MANUAL (July 2000, rev. 045A) at Appendix C § c.5.

Unbundling violations are prosecuted under the False Claims Act, 18 U.S.C. § 287, which also covers claims submitted to private insurers who administer Medicare or Medicaid programs on behalf of the government. Patricia Meador & Elizabeth Warren, *The False Claims Act: A Civil War Relic Evolves into a Modern Weapon*, 65 TENN. L. REV. 455, 462 (Winter 1998). The federal government is targeting health care fraud and has instituted several initiatives aimed at specific practices or providers. *Id.* at 469. One project undertaken by the Department of Justice targeted unbundling at 5,000 hospitals nationwide. *Close to 5,000 Hospitals to be Target of IG/DOJ*

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[7] MEDICARE PART B REFERENCE MANUAL, PROGRAM SAFEGUARDS (July 2000, rev. 045A) at 19-4.

Medicare Unbundling Project, 1 HEALTH CARE FRAUD REP. (BNA) No. 3, at 83 (Feb. 12, 1997).

Thus, under *Simkins*, the same insurer who may provide both HMO and Medicare coverage will be forced to accept unbundling on its ERISA-governed policies, whereas the same practice is forbidden under its Medicare contracts.

* * *

The varying understandings of ambiguity and its relation to medical terms, covered conditions and covered procedures within a plan description governed by ERISA prevent an insurer from writing an EOC that effectively limits its risk while communicating sufficiently with the insured. By defining ambiguity and determining what kinds of language fall into this category, the Supreme Court can create a national standard that will benefit all parties to an HMO insurance contract governed by ERISA.

Question Two

The opinion below perpetuates the split among circuits concerning the use of the *contra proferentem* rule as a matter of ERISA federal common law. To resolve this split, the Court should determine if this rule is applicable to insurance plans governed by ERISA, and, if so, what is its scope?

In *Simkins* the Ninth Circuit applied the *contra proferentem* rule holding that ambiguities in an insurance policy must be read to favor the insured. As argued in

Question One of this petition there is an important question of law as to what constitutes ambiguity in the context of an ERISA EOC. However, regardless of how ambiguity is defined, there is a split among the circuits as to the applicability of *contra proferentem* in ERISA cases.

This split among the circuits makes this issue ripe for a decision by the Court. *Contra proferentem* affects group insurance providers and customers nationwide. The disagreement among the circuits concerning the rule "undermines the uniformity of treatment of ERISA issues and raises significant concerns about the distribution of medical costs between contracting parties." Mark Traynor, *Kunin v. Benefit Trust Life Insurance Co.: Protecting Employees Under ERISA by Construing Ambiguous Terms Against the Insurer*, 77 MINN. L. REV. 1219, 1220 (1993). By settling this dispute, the Court can provide a uniform set of rules for contract interpretation in ERISA cases that will reduce the amount and cost of litigation and, as a result, lower the cost of health care.

Contra proferentem is a common law method of resolving ambiguities against the party who prepared a contract. *McMahan v. New England Mutual Life Ins. Co.*, 888 F.2d 426 (6th Cir. 1989). Presently every state applies some form of the rule. *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 535 (9th Cir. 1990), *cert. denied*, 498 U.S. 1013, 111 S.Ct. 581 (1990). Generally state courts apply the rule where an insured contracts directly with an insurer, however, it has also been applied where an employer purchases a group policy. *See generally* Traynor at 1221-22; *compare to Blue Cross of Northeastern New York, Inc. v. Ayotte*, 315 N.Y.S.2d 998 (N.Y. App. Div. 1970) (court chose not to apply *contra proferentem* in a case involving

an employer purchased policy). Federal courts, relying on state law principles, have applied the rule to resolve disputes over ambiguous contract language in non-ERISA cases. *Westchester Resco Co., LP v. New England Reinsurance Corp.*, 818 F.2d 2, 3 (2d Cir. 1987).

In cases governed by ERISA the federal courts have been instructed to create a "federal common law of rights and obligations." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110-11 (1989).[8] In constructing this common law, the circuits have split as to whether ambiguous terms in an insurance plan should be construed against the insurer. "The circuit courts' inconsistent application of this fundamental contract construction principle hardly exemplifies the 'uniform source of law' envisioned by the drafters of ERISA." Kevin Walker Beatty, *A Decade of Confusion: The Standard of Review for ERISA Benefit Denial Claims as Established by Firestone*, 51 ALA. L.REV. 733 (Winter 2000).

In *Simkins* the Ninth Circuit applies *contra proferentem* as a matter of federal common law. The *Simkins* Court held that the existence of multiple reasonable interpretations on the face of a dispute precludes adopting the insurer's interpretation of plan description language. *Simkins* at 736-37. In addition to the Ninth Circuit, the

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[8] There is disagreement among the circuits on whether the *contra proferentem* rule is saved, pursuant to 29 U.S.C. § 1144, from ERISA preemption. The Sixth Circuit has held that the rule is preempted, *McMahan* at 429-30, while the Ninth Circuit in *Kunin* held that *contra proferentem* could apply as either a saved state law or as a matter of federal common law. *Kunin* at 538-41. Although this issue may be ripe for determination, preemption of *contra proferentem* is not an issue in the instant case.

First, Second, and Seventh Circuits have also adopted *contra proferentem* as a matter of federal common law, however, each circuit applies the rule differently.[9] *Hughes v. Boston Mutual Life Ins. Co.*, 26 F.3d 264, 268-69 (1st Cir. 1994); *Masella v. Blue Cross Blue Shield of Ct., Inc.*, 936 F.2d 98, 107 (2d Cir. 1991); *McNeilly v. Bankers United Life Assurance Co.*, 999 F.2d 1199, 1201 (7th Cir. 1993).

Rejecting *contra proferentem* are the Sixth and Eighth Circuits. *McMahan* at 429-30; *Brewer v. Lincoln Nat'l Life Ins. Co.*, 921 F.2d 150, 153 (8th Cir. 1990), *cert. denied*, 501 U.S. 1238, 111 S.Ct 2872 (1991). The Eighth Circuit, in particular, rejects the use of *contra proferentem* as a matter of federal common law. *Brewer* mandates that "unless the plan language specifies otherwise, courts should construe any disputed language without deferring to either party's

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[9] The First Circuit applies the rule only when the court is incapable of reaching a definitive resolution of the ambiguity from the record. *Hughes* at 268-69. Further, in the First Circuit *contra proferentem* creates a rebuttable presumption favoring the insured's interpretation of a policy. *Id.* The Seventh Circuit strictly construes ambiguous terms against insurers, but only does so when substantial uncertainty over the term exists. *McNeilly* at 1201; *see also Phillips v. Lincoln Nat'l Life Ins. Co.*, 978 F.2d 302, 313 (7th Cir. 1992). This can be compared to the Second Circuit which allows the presentation of evidence to determine if multiple reasonable interpretations exist. *Masella* at 108. The Second Circuit has also held that "rules of construction are 'principles of last resort, to be invoked when efforts to fathom the parties' intent have proved fruitless.' " *O'Neil v. Retirement Plan for Salaried Employees of RKO Gen., Inc.*, 37 F.3d 55, 61 (2d Cir. 1994) *citing Record Club of America, Inc. v. United Artists Records, Inc.*, 890 F.2d 1264, 1271 (2d Cir. 1989).

interpretation." *Brewer* at 153 *citing Firestone* at 1329.[10] Thus, there is a split between those circuits that apply the rule as a matter of federal common law (1st, 2d, 7th and 9th) and those that do not (6th and 8th). Further, even among those circuits where *contra proferentem* is used, there is disagreement as to the scope of its application.

The experience of courts deciding if, when and how to apply *contra proferentem* demonstrates the confusion and controversy surrounding the rule. Traynor at 1229. This Court, as the ultimate authority of federal common law, can cure these problems by determining if the rule is applicable, and, if so, when it should be invoked and the extent to which it should be applied.

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[10] The Tenth Circuit has not yet decided on the applicability of *contra proferentem* as federal common law, but has agreed with the Eighth Circuit that *Firestone v. Bruch* requires an ERISA contract be read without deferring to either parties' interpretation. *McGee v. Equicor-Equitable HCA Corp.*, 953 F.2d 1192 (10th Cir. 1992). Likewise the Third Circuit, in deciding not to address *contra proferentem* specifically, held that it would not adopt a rule that would construe ambiguities against the drafter without first attempting to ascertain the intent of the parties. *Taylor v. Continental Group Change in Control Severance Pay Plan*, 933 F.2d 1227, 1233-34 (3d Cir. 1991).

CONCLUSION

In ruling that unambiguous medical terms are ambiguous per se simply because they are not readily understood by the plan participant, the decision below creates a serious conflict between the legislative purpose of the HMO Act of 1973 to provide low cost health care by limiting risk, and ERISA, which requires a summary plan to be concise and easy to understand. The costly result is that an HMO must, in its plan description, describe each and every procedure covered or excluded by the policy. Under the Ninth Circuit's analysis that a procedure may be covered if some of its component parts are covered, HMOs also risk the increased cost of unbundling.

The Court below applied the *contra proferentem* rule to construe ambiguities against NevadaCare. There is a conflict among the circuits regarding application of the *contra proferentem* rule to ERISA employee welfare benefit plans.

By granting certiorari, this Court could resolve the conflict between the HMO Act of 1973 and ERISA regarding whether medical terms in ERISA summary plan descriptions are per se ambiguous, thus requiring the HMO to adopt elaborate plan descriptions in violation of ERISA. The Court could address the lower court's direction that unbundling with respect to ERISA policies is appropriate. The Court could also resolve the conflict between the circuits regarding application of the *contra proferentem* rule to ERISA employee welfare benefit plans.

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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January 29, 2001

FOR PUBLICATION

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

RUBY SIMKINS; M&K ENTERPRISES, *Plaintiffs-Appellants,* v. NEVADACARE, INC., *Defendant-Appellee.*	No. 99-16844 D.C. No. CV-98-01133-DAE (RJJ) ORDER AND AMENDED OPINION

Appeal from the United States District Court
for the District of Nevada
David A. Ezra, District Judge, Presiding

Argued and Submitted
June 14, 2000—San Francisco, California

Filed October 3, 2000
Amended October 31, 2000

Before: Mary M. Schroeder, Michael Daly Hawkins and Raymond C. Fisher, Circuit Judges.

Opinion by Judge Fisher

SUMMARY

Health/Insurance

The court of appeals reversed and remanded a judgment of the district court. The court held that a reasonable interpretation of a health insurance plan that included coverage for che-

motherapy and blood transfusions but excluded most tissue transplants would include coverage under the plan for high dose chemotherapy with peripheral stem cell rescue for a recurrence of breast cancer.

Appellant Ruby Simkins received health insurance coverage through her employer, appellant M&K Enterprises (M&K). When she was diagnosed with Stage I breast cancer, treatment with radiation therapy was initially successful. Shortly after Simkins enrolled with M&K's new health care provider, appellee NevadaCare, Simkins was diagnosed with Stage IV breast cancer, with at least 12 nodules in her lungs and a plum-sized mass on her liver. She was referred to the UCLA Medical Center for treatment, where her doctor recommended that she undergo high dose chemotherapy with peripheral stem cell rescue (HDC/PSCR). HDC/PSCR is a multistep procedure involving filtering stem cells from the patient's blood, giving the patient high doses of chemotherapy and reinfusing the filtered stem cells back into the bloodstream. NevadaCare denied coverage for the HDC/PSCR procedure under a policy exclusion stating that tissue transplant coverage was limited to allogenic bone marrow only. Simkins paid for the HDC/PSCR treatment and sued NevadaCare for the denial of benefits. NevadaCare's plan was an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974 (ERISA).

The district court denied Simkins's motion for partial summary judgment on the issue of whether NevadaCare's plan covered HDC/PSCR and granted NevadaCare's motion for summary judgment, finding that the plan excluded the requested procedure and that, even if the procedure was not excluded by the tissue transplant exclusion, it was excluded by a catch-all exclusion, encompassing any services or supplies not specifically listed as covered.

[1] Terms in ERISA insurance policies are to be interpreted in an ordinary and popular sense as would a person of average

intelligence and experience. Ambiguous language is construed against the insurer and in favor of the insured.

[2] The district court should have considered whether a person of average intelligence and experience would construe the term "tissue transplant" to encompass HDC/PSCR. The average person would not understand the term "tissue transplant" to encompass HDC/PSCR, because he or she would not understand stem cells to be "tissue." Instead, the average person would focus on the fact that stem cells in this procedure are a component of the patient's blood. Because stem cells would not be understood to be tissue, the average person would have no reason to believe the tissue transplant exclusion extended to HDC/PSCR. It was improper for the district court to grant summary judgment in favor of NevadaCare on this ground.

[3] It was reasonable for the average person to read the plan's benefits section as providing coverage for HDC/PSCR. The plan specifically covered blood and its administration and chemotherapy. An average person would reasonably interpret coverage for "blood" to extend to the specific components of blood, including the stem cells involved here. Therefore, a reasonable interpretation of the plan supported the conclusion that HDC/PSCR was specifically covered, and thus not excluded by the catch-all exclusion.

[4] Because the plan could reasonably be read to cover HDC/PSCR, the district court improperly granted summary judgment to NevadaCare. There existed a reasonable interpretation of the plan that covered HDC/PSCR. Because ambiguous language is construed against the insurer and in favor of the insured, the existence of such a reasonable interpretation meant that, even if contrary reasonable interpretations existed, a jury would be required to adopt the one that favored coverage for the insured. Accordingly, there was no genuine issue for trial on this question, and the district court should have granted Simkins's motion for partial summary judgment.

COUNSEL

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ORDER

The Opinion filed October 3, 2000, is amended as follows:

At slip op. p. 12708, change "We hold that the district court erred in not considering . . ." to "We hold that the district court should have considered . . .".

At slip op. p. 12710, delete footnote 7 and insert the following paragraph after " . . . coverage for HDC/PSCR is not at all compelling.":

> "NevadaCare argues that Simkins waived her argument that the Plan's coverage for chemotherapy and blood transfusions translates into coverage for HDC/PSCR by not raising it before the district court. *See Sofamor Danek Group, Inc. v. Brown*, 124 F.3d 1179, 1186 n.4 (9th Cir. 1997) (noting that an argument generally must be raised in the district court before it will be considered on appeal). NevadaCare reads the waiver rule too broadly. Although Simkins' specific interpretation of the Plan was not expressly raised below, we consider the record sufficient to justify consideration of her more general argument that the Plan is ambiguous and can reasonably be read to include coverage for HDC/PSCR. Accordingly, the general issue is properly before us on appeal, and we are not precluded from considering any reasonable interpretation of the Plan."

OPINION

FISHER, Circuit Judge:

In this appeal, we must determine what forms of treatment a woman recovering from breast cancer would have understood her health insurance plan to cover if her cancer reappeared — specifically, whether it would cover high dose chemotherapy with peripheral stem cell rescue ("HDC/PSCR"). Does NevadaCare's Plan, which includes coverage for chemotherapy and blood transfusions, but which, under an exclusion for organ transplants, excludes most tissue transplants, cover HDC/PSCR?

The district court on summary judgment found that HDC/PSCR was a tissue transplant, clearly excluded from coverage. We hold that the district court erred in not interpreting the Plan's terms from the perspective of an average person. We further hold that a person of average intelligence and experience would interpret the terms of the Plan to include coverage for HDC/PSCR, and we therefore reverse and remand for further proceedings.

Factual and Procedural Background

Simkins worked for M&K Enterprises ("M&K"), her husband's company. In October 1996, Simkins was diagnosed with Stage I breast cancer, which her doctors treated with radiation therapy. Although this treatment was initially successful, her doctors advised her that she would not be considered cured until she had been clear of the cancer for five years. In late 1997, M&K decided to change health care providers and considered contracting with NevadaCare. M&K ultimately decided to sign on with NevadaCare, and Simkins enrolled as a participant/beneficiary of the Plan in January 1998.[1]

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[1]Simkins was clearly cognizant that a change of insurance plans might affect her ability to get the necessary monitoring or obtain necessary treat-

The Plan's Evidence of Coverage ("EOC") booklet describes the covered benefits. Included among the benefits covered are "[b]lood and blood plasma and their administration" and "chemotherapy." Also included are "services required for human tissue and organ transplants," but with a limitation: "Tissue transplant coverage is limited to allogenic bone marrow only."[2] Part VI of the EOC booklet is entitled "Exclusions, Limitations And Non-Covered Services." Two exclusions are relevant here. First, there is a catch-all exclusion, which excludes "[a]ny services or supplies not specifically listed in this Evidence of Coverage as covered benefits, services, or supplies." Second, there is a specific exclusion which states:

> We will cover services for covered organ transplant expenses, as defined below, incurred by a Member for an organ transplant approved by Us at a facility approved by Us, subject to those conditions and limitations described below. . . . We will cover only services, care and treatment received for or in connection with the approved transplantation of the following human organs:
>
> 1. Heart, Kidney, Cornea, and Liver. Liver transplant limited to that required as a result of biliary atresia only.
>
> 2. Tissue transplant coverage is limited to allogenic bone marrow only.

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ment should a relapse occur. She discussed the scope of NevadaCare's coverage with M&K's personnel manager, who found no evidence that the Plan would limit Simkins' available treatment options.

[2]An allogenic bone marrow transplant involves a patient receiving bone marrow from a separate donor. This can be contrasted with an autologous transplant, in which the patient is both the donor and the recipient of the transplanted cells.

Shortly after enrolling in the Plan, Simkins was diagnosed with Stage IV breast cancer, with at least 12 nodules in her lungs and a plum-sized mass on her liver. She was referred to the UCLA Medical Center for treatment, where her doctor recommended that she undergo HDC/PSCR.

According to the research study consent form Simkins signed at UCLA, stem cells are the immature cells in the bone marrow that mature to produce the different kinds of blood cells (red and white blood cells and platelets) that circulate in the blood stream. Although stem cells are found mainly in the bone marrow, there are always some of them circulating in the blood. The patient is given an injection of drugs to stimulate stem cell reproduction and mobilization out of the bone marrow and into the circulating blood. Then, through a series of transfusions, blood is removed from the patient's body and, after passing through a machine that filters out the stem cells, is returned to the body. This "harvesting" procedure may be performed multiple times to collect enough stem cells. During the next phase of the procedure, the patient is given extremely high doses of chemotherapy (HDC) to try to kill off all of the cancer cells, a process that also kills off many of the patient's healthy cells. To help the patient recover more rapidly from the HDC, she is given a transfusion of the previously collected stem cells, which will migrate through the bloodstream into the bone marrow with the hope they will take hold, grow and produce mature red and white blood cells and platelets.

On April 3, 1998, the UCLA Medical Center wrote on Simkins' behalf to NevadaCare requesting coverage for the HDC/PSCR procedure. The request described the procedure as "high dose chemotherapy with autologous peripheral blood stem cell +/- bone marrow support."[3] NevadaCare responded

[3]Presumably, if doctors were unable to harvest a sufficient number of stem cells from the blood, they would have had to collect them directly from the bone marrow. In Simkins' case, however, no bone marrow support was necessary. That the request for coverage letter was sent before the procedure was performed might explain the phrase "+/- bone marrow support."

with a denial of coverage letter on April 30, 1998, which stated:

> The requested services for a [sic] autologous bone marrow transplant for Ruby Simkins has been reviewed and denied as a noncovered benefit. The NevadaCare evidence of coverage (EOC), which you received at the time of enrollment outlines the benefits of transplant services and specifically states that tissue transplant coverage is limited to allogenic bone marrow only. This denial of benefits is a denial of plan coverage and is not related to the medical necessity, per the diagnosis.

Simkins' doctor responded to the denial of benefits on May 11, 1998. In his letter, perhaps misunderstanding NevadaCare's reason for denying coverage, the doctor explained the procedure, emphasizing it was "not an experimental technique."

Because HDC/PSCR offered her the best chances for survival, Simkins secured the funds necessary to pay for the treatment without insurance money. She received the treatment beginning on June 22, 1998, and it appears so far to have been successful, although she still requires follow-up procedures and monitoring.

Simkins sued NevadaCare for the denial of benefits. She filed motions for a permanent injunction and for partial summary judgment on the issue of whether the Plan covers HDC/PSCR. NevadaCare, in turn, filed its own motion for summary judgment, arguing that the Plan excluded the requested procedure. The district court denied Simkins' motions and granted NevadaCare's motion. Simkins appealed.

Standard of Review

A grant of summary judgment is reviewed *de novo*. *Balint v. Carson City*, 180 F.3d 1047, 1050 (9th Cir. 1999) (en

banc). Viewing the evidence in the light most favorable to the nonmoving party and drawing all reasonable inferences in its favor, an appellate court must determine whether the district court correctly applied the relevant substantive law and whether there are any genuine issues of material fact. *See id.*

Because the Plan is an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, we review *de novo* "the district court's choice and application of the standard of review applicable to decisions by fiduciaries in the ERISA context." *Lang v. Long-Term Disability Plan*, 125 F.3d 794, 797 (9th Cir. 1997). Courts review *de novo* a denial of benefits under an ERISA plan " 'unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.' " *Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1089 (9th Cir.) (en banc) (quoting *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989)), *cert. denied*, 120 S. Ct. 398 (1999). The burden is on the administrator to show that the plan gives it such discretionary authority. *See id.* The plan's reservation of discretion must be unambiguous to overcome the presumption of *de novo* review. *See McDaniel v. Chevron Corp.*, 203 F.3d 1099, 1107 (9th Cir. 2000) (citing *Kearney*, 175 F.3d at 1088-89).

NevadaCare contends the Plan gives it discretionary authority, so the abuse of discretion standard should apply. The district court appeared to agree with NevadaCare, but found that, even under a *de novo* standard, NevadaCare's denial of benefits would have been proper.

NevadaCare points to three places in the Plan that it alleges give it the necessary discretion. None is sufficient. The first two are found in the "Definitions" section of the plan. First, "Medically Necessary" is defined as: "The use of services and/or supplies, as described in this Evidence of Coverage, which are required to identify or treat Your illness or injury

and which are . . . consistent with medical policy and procedure as defined by the NevadaCare Quality Management Program." NevadaCare's discretion to define medical policy and procedure is not the same as discretion to construe the terms of the Plan. Moreover, medical necessity was not an issue in this case, so the court is not reviewing NevadaCare's exercise of discretion in defining medical policy and procedure.[4]

Second, under the definition for "Prior/Pre-Authorization," the Plan states, "[A] Participating Provider or Physician must receive approval from an authorized staff member of NevadaCare, such as the Medical Director or his designee, before You receive certain health care services." Nothing in this definition unambiguously gives NevadaCare discretion to construe the terms of the Plan; it merely notes that a beneficiary may have to receive prior approval before receiving certain benefits.

Lastly, Part XI of the Plan, entitled "Member Rights and Responsibilities," describes the "Complaint and Grievance Procedure":

> You have the right to express Your concerns and problems regarding Your NevadaCare coverage and benefits. You are encouraged to contact Member Services with any questions or problems as soon as they arise. NevadaCare is committed to providing prompt and responsive service to all Members.
>
> If you are unhappy with the answer You receive, You can tell the Member Services Representative You wish to file a grievance. . . .
>
> NevadaCare will make a final decision for [sic]

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[4]The denial of coverage letter from NevadaCare stated that the denial of benefits in this case was "a denial of plan coverage and [was] *not related to the medical necessity*, per the diagnosis." (Emphasis added.)

> grievance about medical care services within fifteen (15) days of receiving written or oral grievance. A letter will be mailed to You stating NevadaCare's decision and the reason for the decision. The letter will tell You how You can appeal the decision if You are not satisfied. You must let NevadaCare know if You want to appeal the decision.

Again, nothing in this description of the grievance procedure unambiguously gives NevadaCare discretion to construe the terms of the Plan.

Comparing the above three statements to the statements in plans we have found to have granted discretion unambiguously to plan administrators, we find a stark contrast. The plan in *McDaniel*, for example, provided that "the Plan Administrator has the 'sole discretion to interpret the terms of the Plan' and those interpretations 'shall be conclusive and binding.' " 203 F.3d at 1107. The plan in *Bendixen v. Standard Insurance Co.* stated, "we have full and exclusive authority . . . to interpret the Group Policy and resolve all questions arising in the administration, interpretation, and application of the Group Policy." 185 F.3d 939, 943 n.1 (9th Cir. 1999). The plan in *Atwood v. Newmont Gold Co.* specified that the administrator "shall be the sole and exclusive judge as to whether or not a termination is qualified for benefits under the terms of this Plan." 45 F.3d 1317, 1321 (9th Cir. 1995). Because the Plan's language in the present case does not unambiguously grant NevadaCare discretion to interpret the terms of the Plan, we review *de novo* NevadaCare's denial of benefits.

Discussion

[1] We turn now to the proper interpretation of NevadaCare's Plan and whether it covers or excludes HDC/PSCR. Terms in ERISA insurance policies are to be interpreted "in an ordinary and popular sense as would a [person] of average

intelligence and experience." *Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1441 (9th Cir. 1990) (internal quotation marks omitted) (alteration in original). "[A]mbiguous language is construed against the insurer and in favor of the insured." *McClure v. Life Ins. Co. of N. Am.*, 84 F.3d 1129, 1134 (9th Cir. 1996). However, we should "not artificially create ambiguity where none exists. If a reasonable interpretation favors the insurer and any other interpretation would be strained, no compulsion exists to torture or twist the language of the policy." *Evans*, 916 F.2d at 1441 (internal quotation marks and citation omitted).

Simkins argued before the district court that the Plan's exclusions were ambiguous and confusing and that a reasonable beneficiary would not read the Plan as excluding HDC/PSCR. Specifically, the exclusion, "Tissue transplant coverage is limited to allogenic bone marrow only," is found within a section that begins "We will cover services for covered organ transplant expenses, as defined below . . . ." In her motion papers, Simkins emphasized the difference between allogenic bone marrow transplants and HDC/PSCR, and argued she was "not requesting an *organ transplant* but rather a transfusion of her stem cells." *Plaintiff's Motion for Permanent Injunction*, at 16 (emphasis in original).

The district court granted NevadaCare's summary judgment motion, noting that "[r]egardless of whether these are two different procedures, the undisputed evidence shows that they are both tissue transplants." The court then concluded that, because the plain, unambiguous language of the Plan limits tissue transplants to allogenic bone marrow transplants, which HDC/PSCR is not, the denial of benefits was proper.

[2] We hold that the district court should have considered whether a person of average intelligence and experience would construe the term "tissue transplant" to encompass HDC/PSCR. We believe the average person would not understand the term "tissue transplant" to encompass HDC/PSCR,

because she would not understand stem cells to be "tissue." Instead, the average person would focus on the fact that stem cells in this procedure are a component of the patient's blood. Indeed, the research study consent form Simkins signed specifically mentions that the stem cells would be collected from her blood stream. The average person is not likely to understand blood to be tissue, especially when the Plan specifically discusses blood transfusions separately from tissue transplants and places tissue transplant coverage within the *organ* transplant section, a locational choice that has a distinct potential of misleading and confusing average plan participants.[5] Because stem cells would not be understood to be tissue, the average person would have no reason to believe the tissue transplant exclusion extended to HDC/PSCR. Accordingly, it was improper for the district court to grant summary judgment in favor of NevadaCare on this ground.

NevadaCare also argued, and the district court agreed, that even if the procedure is not excluded by the tissue transplant exclusion, it is excluded by the catch-all exclusion, encompassing "[a]ny services or supplies not specifically listed in this Evidence of Coverage as covered benefits, services, or supplies." Our determination of this contention turns on how an average person would interpret the Plan's "Services and Benefits" section, and whether the specific listed benefits in this section can reasonably be interpreted to include HDC/PSCR.

[3] We believe it is reasonable for the average person to read the Plan's benefits section as providing coverage for HDC/PSCR. As noted above, HDC/PSCR is a multistep pro-

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[5]This understanding would be consistent with the dictionary definitions of "tissue" and "stem cell." Under "tissue," the dictionary states, "There are four basic types of tissue: muscle, nerve, epidermal, and connective." THE AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE 1880 (3d ed. 1996). "Stem cell" is defined as "[a]n unspecified cell that gives rise to a specific, specialized cell, such as a blood cell." *Id.* at 1761.

cedure involving filtering stem cells from the patient's blood, giving the patient high doses of chemotherapy and reinfusing the filtered stem cells back into the bloodstream. The research study overview that Simkins signed described the reinfusion of stem cells to be "like a transfusion." The Plan specifically covers blood and its administration and chemotherapy. Neither blood nor chemotherapy is defined. An average person would reasonably interpret coverage for "blood" to extend to the specific components of blood, including the stem cells involved here. An average person would also reasonably conclude that the general term "chemotherapy" covers all levels of chemotherapy used in treatment. If both steps of HDC/PSCR are covered separately, the average person would find it highly unlikely that they would not be covered when performed together.[6] Therefore, a reasonable interpretation of the Plan supports the conclusion that HDC/PSCR is specifically covered, and thus not excluded by the catch-all exclusion.

As we have noted previously, "the insurer should be expected to set forth any limitations on its liability clearly enough for a common layperson to understand; if it fails to do this, it should not be allowed to take advantage of the very ambiguities that it could have prevented with greater diligence." *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 540 (9th Cir. 1990). Ruby Simkins knew there was a risk her cancer would return, and she made an effort to ensure that her

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[6]Relying on *Hendricks v. Central Reserve Life Insurance Co.*, 39 F.3d 507 (4th Cir. 1994), NevadaCare argues that it is improper to fragment HDC/PSCR into its component parts for the purpose of determining whether the Plan covers the procedure. The insurer in *Hendricks* denied coverage for HDC/PSCR under an exclusion for "experimental/investigative" procedures. *See* 39 F.3d at 509. Although we do not comment on the wisdom of prohibiting fragmentation in that context, its use here is clearly distinguishable. We are determining whether an average person reasonably would interpret the Plan as covering HDC/PSCR. An average person trying to assess whether an insurance plan covered a complex procedure reasonably would look to whether the component parts are covered to make that determination.

transfer to a NevadaCare insurance plan would not limit her potential treatment options in the event of such an unfortunate recurrence. If NevadaCare wishes to exclude coverage of a procedure such as HDC/PSCR from its insurance plans, it should do so conspicuously and unambiguously so a reasonable insured can determine this fact by looking at her policy. Its subsequent reliance on an exclusion for "tissue transplants" — and worse, a "catch-all" exclusion — to exclude coverage for HDC/PSCR is not at all compelling.

NevadaCare argues that Simkins waived her argument that the Plan's coverage for chemotherapy and blood transfusions translates into coverage for HDC/PSCR by not raising it before the district court. *See Sofamor Danek Group, Inc. v. Brown*, 124 F.3d 1179, 1186 n.4 (9th Cir. 1997) (noting that an argument generally must be raised in the district court before it will be considered on appeal). NevadaCare reads the waiver rule too broadly. Although Simkins' specific interpretation of the Plan was not expressly raised below, we consider the record sufficient to justify consideration of her more general argument that the Plan is ambiguous and can reasonably be read to include coverage for HDC/PSCR. Accordingly, the general issue is properly before us on appeal, and we are not precluded from considering any reasonable interpretation of the Plan.

[4] Because the Plan can reasonably be read to cover HDC/PSCR, the district court improperly granted summary judgment to NevadaCare. The only remaining question, then, is whether the district court properly denied Simkins' motion for partial summary judgment, which sought a determination that the Plan covered HDC/PSCR. As we have held, there exists a reasonable interpretation of the Plan that covers HDC/PSCR. Because "ambiguous language is construed against the insurer and in favor of the insured," *McClure*, 84 F.3d at 1134, the existence of such a reasonable interpretation means that, even if contrary reasonable interpretations exist, a jury would be required to adopt the one that favors coverage for

the insured. Accordingly, there is no genuine issue for trial on this question, and the district court should have granted Simkins' motion for partial summary judgment.

REVERSED and REMANDED for further proceedings consistent with this opinion.

FOR PUBLICATION

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

RUBY SIMKINS; M&K ENTERPRISES, *Plaintiffs-Appellants,* v. NEVADACARE, INC., *Defendant-Appellee.*	No. 99-16844 D.C. No. CV-98-01133-DAE (RJJ) OPINION

Appeal from the United States District Court
for the District of Nevada
David A. Ezra, District Judge, Presiding

Argued and Submitted
June 14, 2000—San Francisco, California

Filed October 3, 2000

Before: Mary M. Schroeder, Michael Daly Hawkins and Raymond C. Fisher, Circuit Judges.

Opinion by Judge Fisher

SUMMARY

Health/Insurance

The court of appeals reversed and remanded a judgment of the district court. The court held that a reasonable interpretation of a health insurance plan that included coverage for chemotherapy and blood transfusions but excluded most tissue transplants would include coverage under the plan for high dose chemotherapy with peripheral stem cell rescue for a recurrence of breast cancer.

Appellant Ruby Simkins received health insurance coverage through her employer, appellant M&K Enterprises (M&K). When she was diagnosed with Stage I breast cancer, treatment with radiation therapy was initially successful. Shortly after Simkins enrolled with M&K's new health care provider, appellee NevadaCare, Simkins was diagnosed with Stage IV breast cancer, with at least 12 nodules in her lungs and a plum-sized mass on her liver. She was referred to the UCLA Medical Center for treatment, where her doctor recommended that she undergo high dose chemotherapy with peripheral stem cell rescue (HDC/PSCR). HDC/PSCR is a multistep procedure involving filtering stem cells from the patient's blood, giving the patient high doses of chemotherapy and reinfusing the filtered stem cells back into the bloodstream. NevadaCare denied coverage for the HDC/PSCR procedure under a policy exclusion stating that tissue transplant coverage was limited to allogenic bone marrow only. Simkins paid for the HDC/PSCR treatment and sued NevadaCare for the denial of benefits. NevadaCare's plan was an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974 (ERISA).

The district court denied Simkins's motion for partial summary judgment on the issue of whether NevadaCare's plan covered HDC/PSCR and granted NevadaCare's motion for summary judgment, finding that the plan excluded the requested procedure and that, even if the procedure was not excluded by the tissue transplant exclusion, it was excluded by a catch-all exclusion, encompassing any services or supplies not specifically listed as covered.

[1] Terms in ERISA insurance policies are to be interpreted in an ordinary and popular sense as would a person of average intelligence and experience. Ambiguous language is construed against the insurer and in favor of the insured.

[2] The district court erred in not considering whether a person of average intelligence and experience would construe

the term "tissue transplant" to encompass HDC/PSCR. The average person would not understand the term "tissue transplant" to encompass HDC/PSCR, because he or she would not understand stem cells to be "tissue." Instead, the average person would focus on the fact that stem cells in this procedure are a component of the patient's blood. Because stem cells would not be understood to be tissue, the average person would have no reason to believe the tissue transplant exclusion extended to HDC/PSCR. It was improper for the district court to grant summary judgment in favor of NevadaCare on this ground.

[3] It was reasonable for the average person to read the plan's benefits section as providing coverage for HDC/PSCR. The plan specifically covered blood and its administration and chemotherapy. An average person would reasonably interpret coverage for "blood" to extend to the specific components of blood, including the stem cells involved here. Therefore, a reasonable interpretation of the plan supported the conclusion that HDC/PSCR was specifically covered, and thus not excluded by the catch-all exclusion.

[4] Because the plan could reasonably be read to cover HDC/PSCR, the district court improperly granted summary judgment to NevadaCare. There existed a reasonable interpretation of the plan that covered HDC/PSCR. Because ambiguous language is construed against the insurer and in favor of the insured, the existence of such a reasonable interpretation meant that, even if contrary reasonable interpretations existed, a jury would be required to adopt the one that favored coverage for the insured. Accordingly, there was no genuine issue for trial on this question, and the district court should have granted Simkins's motion for partial summary judgment.

COUNSEL

Edgar Carranza, Backus & Delikanakis, Las Vegas, Nevada, for the plaintiffs-appellants.

Constance L. Akridge, Wadhams & Akridge, P.C., Las Vegas, Nevada, for the defendant-appellee.

OPINION

FISHER, Circuit Judge:

In this appeal, we must determine what forms of treatment a woman recovering from breast cancer would have understood her health insurance plan to cover if her cancer reappeared — specifically, whether it would cover high dose chemotherapy with peripheral stem cell rescue ("HDC/PSCR"). Does NevadaCare's Plan, which includes coverage for chemotherapy and blood transfusions, but which, under an exclusion for organ transplants, excludes most tissue transplants, cover HDC/PSCR?

The district court on summary judgment found that HDC/PSCR was a tissue transplant, clearly excluded from coverage. We hold that the district court erred in not interpreting the Plan's terms from the perspective of an average person. We further hold that a person of average intelligence and experience would interpret the terms of the Plan to include coverage for HDC/PSCR, and we therefore reverse and remand for further proceedings.

Factual and Procedural Background

Simkins worked for M&K Enterprises ("M&K"), her husband's company. In October 1996, Simkins was diagnosed with Stage I breast cancer, which her doctors treated with radiation therapy. Although this treatment was initially successful, her doctors advised her that she would not be considered cured until she had been clear of the cancer for five years. In late 1997, M&K decided to change health care providers and considered contracting with NevadaCare. M&K

ultimately decided to sign on with NevadaCare, and Simkins enrolled as a participant/beneficiary of the Plan in January 1998.[1]

The Plan's Evidence of Coverage ("EOC") booklet describes the covered benefits. Included among the benefits covered are "[b]lood and blood plasma and their administration" and "chemotherapy." Also included are "services required for human tissue and organ transplants," but with a limitation: "Tissue transplant coverage is limited to allogenic bone marrow only."[2] Part VI of the EOC booklet is entitled "Exclusions, Limitations And Non-Covered Services." Two exclusions are relevant here. First, there is a catch-all exclusion, which excludes "[a]ny services or supplies not specifically listed in this Evidence of Coverage as covered benefits, services, or supplies." Second, there is a specific exclusion which states:

> We will cover services for covered organ transplant expenses, as defined below, incurred by a Member for an organ transplant approved by Us at a facility approved by Us, subject to those conditions and limitations described below. . . . We will cover only services, care and treatment received for or in connection with the approved transplantation of the following human organs:
>
> 1. Heart, Kidney, Cornea, and Liver.

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[1]Simkins was clearly cognizant that a change of insurance plans might affect her ability to get the necessary monitoring or obtain necessary treatment should a relapse occur. She discussed the scope of NevadaCare's coverage with M&K's personnel manager, who found no evidence that the Plan would limit Simkins' available treatment options.

[2]An allogenic bone marrow transplant involves a patient receiving bone marrow from a separate donor. This can be contrasted with an autologous transplant, in which the patient is both the donor and the recipient of the transplanted cells.

Liver transplant limited to that required as a result of biliary atresia only.

2. Tissue transplant coverage is limited to allogenic bone marrow only.

Shortly after enrolling in the Plan, Simkins was diagnosed with Stage IV breast cancer, with at least 12 nodules in her lungs and a plum-sized mass on her liver. She was referred to the UCLA Medical Center for treatment, where her doctor recommended that she undergo HDC/PSCR.

According to the research study consent form Simkins signed at UCLA, stem cells are the immature cells in the bone marrow that mature to produce the different kinds of blood cells (red and white blood cells and platelets) that circulate in the blood stream. Although stem cells are found mainly in the bone marrow, there are always some of them circulating in the blood. The patient is given an injection of drugs to stimulate stem cell reproduction and mobilization out of the bone marrow and into the circulating blood. Then, through a series of transfusions, blood is removed from the patient's body and, after passing through a machine that filters out the stem cells, is returned to the body. This "harvesting" procedure may be performed multiple times to collect enough stem cells. During the next phase of the procedure, the patient is given extremely high doses of chemotherapy (HDC) to try to kill off all of the cancer cells, a process that also kills off many of the patient's healthy cells. To help the patient recover more rapidly from the HDC, she is given a transfusion of the previously collected stem cells, which will migrate through the bloodstream into the bone marrow with the hope they will take hold, grow and produce mature red and white blood cells and platelets.

On April 3, 1998, the UCLA Medical Center wrote on Simkins' behalf to NevadaCare requesting coverage for the HDC/PSCR procedure. The request described the procedure as "high dose chemotherapy with autologous peripheral blood

stem cell +/- bone marrow support."[3] NevadaCare responded with a denial of coverage letter on April 30, 1998, which stated:

> The requested services for a [sic] autologous bone marrow transplant for Ruby Simkins has been reviewed and denied as a noncovered benefit. The NevadaCare evidence of coverage (EOC), which you received at the time of enrollment outlines the benefits of transplant services and specifically states that tissue transplant coverage is limited to allogenic bone marrow only. This denial of benefits is a denial of plan coverage and is not related to the medical necessity, per the diagnosis.

Simkins' doctor responded to the denial of benefits on May 11, 1998. In his letter, perhaps misunderstanding NevadaCare's reason for denying coverage, the doctor explained the procedure, emphasizing it was "not an experimental technique."

Because HDC/PSCR offered her the best chances for survival, Simkins secured the funds necessary to pay for the treatment without insurance money. She received the treatment beginning on June 22, 1998, and it appears so far to have been successful, although she still requires follow-up procedures and monitoring.

Simkins sued NevadaCare for the denial of benefits. She filed motions for a permanent injunction and for partial summary judgment on the issue of whether the Plan covers HDC/

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[3]Presumably, if doctors were unable to harvest a sufficient number of stem cells from the blood, they would have had to collect them directly from the bone marrow. In Simkins' case, however, no bone marrow support was necessary. That the request for coverage letter was sent before the procedure was performed might explain the phrase "+/- bone marrow support."

PSCR. NevadaCare, in turn, filed its own motion for summary judgment, arguing that the Plan excluded the requested procedure. The district court denied Simkins' motions and granted NevadaCare's motion. Simkins appealed.

Standard of Review

A grant of summary judgment is reviewed *de novo*. *Balint v. Carson City*, 180 F.3d 1047, 1050 (9th Cir. 1999) (en banc). Viewing the evidence in the light most favorable to the nonmoving party and drawing all reasonable inferences in its favor, an appellate court must determine whether the district court correctly applied the relevant substantive law and whether there are any genuine issues of material fact. *See id.*

Because the Plan is an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, we review *de novo* "the district court's choice and application of the standard of review applicable to decisions by fiduciaries in the ERISA context." *Lang v. Long-Term Disability Plan*, 125 F.3d 794, 797 (9th Cir. 1997). Courts review *de novo* a denial of benefits under an ERISA plan " 'unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.' " *Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1089 (9th Cir.) (en banc) (quoting *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989)), *cert. denied*, 120 S. Ct. 398 (1999). The burden is on the administrator to show that the plan gives it such discretionary authority. *See id.* The plan's reservation of discretion must be unambiguous to overcome the presumption of *de novo* review. *See McDaniel v. Chevron Corp.*, 203 F.3d 1099, 1107 (9th Cir. 2000) (citing *Kearney*, 175 F.3d at 1088-89).

NevadaCare contends the Plan gives it discretionary authority, so the abuse of discretion standard should apply. The district court appeared to agree with NevadaCare, but

found that, even under a *de novo* standard, NevadaCare's denial of benefits would have been proper.

NevadaCare points to three places in the Plan that it alleges give it the necessary discretion. None is sufficient. The first two are found in the "Definitions" section of the plan. First, "Medically Necessary" is defined as: "The use of services and/or supplies, as described in this Evidence of Coverage, which are required to identify or treat Your illness or injury and which are . . . consistent with medical policy and procedure as defined by the NevadaCare Quality Management Program." NevadaCare's discretion to define medical policy and procedure is not the same as discretion to construe the terms of the Plan. Moreover, medical necessity was not an issue in this case, so the court is not reviewing NevadaCare's exercise of discretion in defining medical policy and procedure.[4]

Second, under the definition for "Prior/Pre-Authorization," the Plan states, "[A] Participating Provider or Physician must receive approval from an authorized staff member of NevadaCare, such as the Medical Director or his designee, before You receive certain health care services." Nothing in this definition unambiguously gives NevadaCare discretion to construe the terms of the Plan; it merely notes that a beneficiary may have to receive prior approval before receiving certain benefits.

Lastly, Part XI of the Plan, entitled "Member Rights and Responsibilities," describes the "Complaint and Grievance Procedure":

> You have the right to express Your concerns and problems regarding Your NevadaCare coverage and benefits. You are encouraged to contact Member

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[4]The denial of coverage letter from NevadaCare stated that the denial of benefits in this case was "a denial of plan coverage and [was] *not related to the medical necessity*, per the diagnosis." (Emphasis added.)

> Services with any questions or problems as soon as they arise. NevadaCare is committed to providing prompt and responsive service to all Members.
>
> If you are unhappy with the answer You receive, You can tell the Member Services Representative You wish to file a grievance. . . .
>
> NevadaCare will make a final decision for [sic] grievance about medical care services within fifteen (15) days of receiving written or oral grievance. A letter will be mailed to You stating NevadaCare's decision and the reason for the decision. The letter will tell You how You can appeal the decision if You are not satisfied. You must let NevadaCare know if You want to appeal the decision.

Again, nothing in this description of the grievance procedure unambiguously gives NevadaCare discretion to construe the terms of the Plan.

Comparing the above three statements to the statements in plans we have found to have granted discretion unambiguously to plan administrators, we find a stark contrast. The plan in *McDaniel*, for example, provided that "the Plan Administrator has the 'sole discretion to interpret the terms of the Plan' and those interpretations 'shall be conclusive and binding.' " 203 F.3d at 1107. The plan in *Bendixen v. Standard Insurance Co.* stated, "we have full and exclusive authority . . . to interpret the Group Policy and resolve all questions arising in the administration, interpretation, and application of the Group Policy." 185 F.3d 939, 943 n.1 (9th Cir. 1999). The plan in *Atwood v. Newmont Gold Co.* specified that the administrator "shall be the sole and exclusive judge as to whether or not a termination is qualified for benefits under the terms of this Plan." 45 F.3d 1317, 1321 (9th Cir. 1995). Because the Plan's language in the present case does not unambiguously grant NevadaCare discretion to interpret the

terms of the Plan, we review *de novo* NevadaCare's denial of benefits.

Discussion

[1] We turn now to the proper interpretation of NevadaCare's Plan and whether it covers or excludes HDC/PSCR. Terms in ERISA insurance policies are to be interpreted "in an ordinary and popular sense as would a [person] of average intelligence and experience." *Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1441 (9th Cir. 1990) (internal quotation marks omitted) (alteration in original). "[A]mbiguous language is construed against the insurer and in favor of the insured." *McClure v. Life Ins. Co. of N. Am.*, 84 F.3d 1129, 1134 (9th Cir. 1996). However, we should "not artificially create ambiguity where none exists. If a reasonable interpretation favors the insurer and any other interpretation would be strained, no compulsion exists to torture or twist the language of the policy." *Evans*, 916 F.2d at 1441 (internal quotation marks and citation omitted).

Simkins argued before the district court that the Plan's exclusions were ambiguous and confusing and that a reasonable beneficiary would not read the Plan as excluding HDC/PSCR. Specifically, the exclusion, "Tissue transplant coverage is limited to allogenic bone marrow only," is found within a section that begins "We will cover services for covered organ transplant expenses, as defined below . . . ." In her motion papers, Simkins emphasized the difference between allogenic bone marrow transplants and HDC/PSCR, and argued she was "not requesting an *organ transplant* but rather a transfusion of her stem cells." *Plaintiff's Motion for Permanent Injunction*, at 16 (emphasis in original).

The district court granted NevadaCare's summary judgment motion, noting that "[r]egardless of whether these are two different procedures, the undisputed evidence shows that they are both tissue transplants." The court then concluded

that, because the plain, unambiguous language of the Plan limits tissue transplants to allogenic bone marrow transplants, which HDC/PSCR is not, the denial of benefits was proper.

[2] We hold that the district court erred in not considering whether a person of average intelligence and experience would construe the term "tissue transplant" to encompass HDC/PSCR. We believe the average person would not understand the term "tissue transplant" to encompass HDC/PSCR, because she would not understand stem cells to be "tissue." Instead, the average person would focus on the fact that stem cells in this procedure are a component of the patient's blood. Indeed, the research study consent form Simkins signed specifically mentions that the stem cells would be collected from her blood stream. The average person is not likely to understand blood to be tissue, especially when the Plan specifically discusses blood transfusions separately from tissue transplants and places tissue transplant coverage within the *organ* transplant section, a locational choice that has a distinct potential of misleading and confusing average plan participants.[5] Because stem cells would not be understood to be tissue, the average person would have no reason to believe the tissue transplant exclusion extended to HDC/PSCR. Accordingly, it was improper for the district court to grant summary judgment in favor of NevadaCare on this ground.

NevadaCare also argued, and the district court agreed, that even if the procedure is not excluded by the tissue transplant exclusion, it is excluded by the catch-all exclusion, encompassing "[a]ny services or supplies not specifically listed in this Evidence of Coverage as covered benefits, services, or

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[5]This understanding would be consistent with the dictionary definitions of "tissue" and "stem cell." Under "tissue," the dictionary states, "There are four basic types of tissue: muscle, nerve, epidermal, and connective." THE AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE 1880 (3d ed. 1996). "Stem cell" is defined as "[a]n unspecified cell that gives rise to a specific, specialized cell, such as a blood cell." *Id.* at 1761.

supplies." Our determination of this contention turns on how an average person would interpret the Plan's "Services and Benefits" section, and whether the specific listed benefits in this section can reasonably be interpreted to include HDC/PSCR.

[3] We believe it is reasonable for the average person to read the Plan's benefits section as providing coverage for HDC/PSCR. As noted above, HDC/PSCR is a multistep procedure involving filtering stem cells from the patient's blood, giving the patient high doses of chemotherapy and reinfusing the filtered stem cells back into the bloodstream. The research study overview that Simkins signed described the reinfusion of stem cells to be "like a transfusion." The Plan specifically covers blood and its administration and chemotherapy. Neither blood nor chemotherapy is defined. An average person would reasonably interpret coverage for "blood" to extend to the specific components of blood, including the stem cells involved here. An average person would also reasonably conclude that the general term "chemotherapy" covers all levels of chemotherapy used in treatment. If both steps of HDC/PSCR are covered separately, the average person would find it highly unlikely that they would not be covered when performed together.[6] Therefore, a reasonable interpretation of the

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[6]Relying on *Hendricks v. Central Reserve Life Insurance Co.*, 39 F.3d 507 (4th Cir. 1994), NevadaCare argues that it is improper to fragment HDC/PSCR into its component parts for the purpose of determining whether the Plan covers the procedure. The insurer in *Hendricks* denied coverage for HDC/PSCR under an exclusion for "experimental/investigative" procedures. *See* 39 F.3d at 509. Although we do not comment on the wisdom of prohibiting fragmentation in that context, its use here is clearly distinguishable. We are determining whether an average person reasonably would interpret the Plan as covering HDC/PSCR. An average person trying to assess whether an insurance plan covered a complex procedure reasonably would look to whether the component parts are covered to make that determination.

Plan supports the conclusion that HDC/PSCR is specifically covered, and thus not excluded by the catch-all exclusion.[7]

As we have noted previously, "the insurer should be expected to set forth any limitations on its liability clearly enough for a common layperson to understand; if it fails to do this, it should not be allowed to take advantage of the very ambiguities that it could have prevented with greater diligence." *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 540 (9th Cir. 1990). Ruby Simkins knew there was a risk her cancer would return, and she made an effort to ensure that her transfer to a NevadaCare insurance plan would not limit her potential treatment options in the event of such an unfortunate recurrence. If NevadaCare wishes to exclude coverage of a procedure such as HDC/PSCR from its insurance plans, it should do so conspicuously and unambiguously so a reasonable insured can determine this fact by looking at her policy. Its subsequent reliance on an exclusion for "tissue transplants" — and worse, a "catch-all" exclusion — to exclude coverage for HDC/PSCR is not at all compelling.

[4] Because the Plan can reasonably be read to cover HDC/PSCR, the district court improperly granted summary judgment to NevadaCare. The only remaining question, then, is

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[7]NevadaCare argues that Simkins waived her argument that the Plan's coverage for chemotherapy and blood transfusions translates into coverage for HDC/PSCR by not raising it before the district court. "Before an argument will be considered on appeal, the argument must be raised sufficiently for the trial court to rule on it." *Sofamor Danek Group, Inc. v. Brown*, 124 F.3d 1179, 1186 n.4 (9th Cir. 1997) (internal quotation marks and citation omitted). NevadaCare reads the waiver rule too broadly. Although Simkins' specific interpretation of the Plan was not expressly raised below, her more general argument that the Plan is ambiguous and can reasonably be read to include coverage for HDC/PSCR was. This gave the district court the opportunity to examine the Plan and rule on whether an average person reasonably could interpret the Plan to include coverage for HDC/PSCR. Accordingly, the general issue is properly before us on appeal, and we are not precluded from considering any reasonable interpretation of the Plan.

whether the district court properly denied Simkins' motion for partial summary judgment, which sought a determination that the Plan covered HDC/PSCR. As we have held, there exists a reasonable interpretation of the Plan that covers HDC/PSCR. Because "ambiguous language is construed against the insurer and in favor of the insured," *McClure*, 84 F.3d at 1134, the existence of such a reasonable interpretation means that, even if contrary reasonable interpretations exist, a jury would be required to adopt the one that favors coverage for the insured. Accordingly, there is no genuine issue for trial on this question, and the district court should have granted Simkins' motion for partial summary judgment.

REVERSED and REMANDED for further proceedings consistent with this opinion.

**AO 450 (Rev. 5/85) Judgment in a Civil Case

UNITED STATES DISTRICT COURT

***** DISTRICT OF NEVADA

RUBY SIMKINS and
M & K ENTERPRISES,
a proprietorship,

Plaintiffs,

V.

NEVADACARE, INC., a
Nevada corporation,
JOHN DOES I through X
and DOE CORPORATIONS
I through X,

Defendants.
_____/

JUDGMENT IN A CIVIL CASE

(Filed Jul. 20, 1999)

CV-S-98-1133-DAE(RJJ)

__ **Jury Verdict.** This action came before the jury for a trial by the Court. The issues have been tried and the jury has rendered it's [sic] verdict.

X **Decision by Court.** This action came to be considered by the Court. The issues have been considered and a decision has been rendered.

IT IS ORDERED AND ADJUDGED that Plaintiff's Motion for Permanent Injunction and Motion for Partial Summary Judgment are DENIED and Defendant NevadaCare's Countermotion for Summary Judgment is GRANTED. Judgment is for the Defendant and against the Plaintiffs.

July 20, 1999
Date

/s/ LANCE S. WILSON
Clerk

/s/ Kathy Yapich
(By) Deputy Clerk

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEVADA

RUBY SIMKINS AND M & K ENTERPRISES, a proprietorship, Plaintiffs, vs. NEVADACARE, INC., a Nevada corporation, JOHN DOES I Through X and DOE CORPORATIONS I through X, Defendants.	CV-S-98-01133-DAE (RJJ)

ORDER DENYING PLAINTIFFS' MOTION FOR PERMANENT INJUNCTION AND MOTION FOR PARTIAL SUMMARY JUDGMENT; GRANTING DEFENDANT NEVADACARE'S COUNTERMOTION FOR SUMMARY JUDGMENT

ENTERED AND SERVED JUL. 20, 1999

The court heard Plaintiffs' and Defendant NevadaCare's Motions on June 22, 1999. Leland Eugene Backus, Esq., appeared at the hearing on behalf of Plaintiffs; Constance L. Akridge, Esq., appeared on behalf of Defendant NevadaCare. After reviewing the motion and the supporting and opposing memoranda, the court DENIES Plaintiffs' Motion for Permanent Injunction and Motion for Partial Summary Judgment and GRANTS Defendant NevadaCare's Countermotion for Summary Judgment.

BACKGROUND

This case arises from Defendant NevadaCare, Inc.'s ("NevadaCare") refusal to pay for Plaintiff Ruby Simkins' ("Ms. Simkins") breast cancer treatment, known as high dose chemotherapy with peripheral stem cell rescue. Ms. Simkins was first diagnosed with breast cancer in October 1996. Following diagnosis, she underwent a lumpectomy followed by systemic radiation therapy. Ms. Simkins successfully completed her radiation therapy in January 1997. Despite such hopeful progress, her physicians told her that she would not be considered "cured" until the cancer had been in remission for five years.

In late 1997, Ms. Simkins' employer M & K Enterprises ("M & K") began searching for a new health care provider. NevadaCare submitted a price quote to M & K through an insurance broker, Layne & Associates. Subsequently, M & K's personnel manager, Cindy Martell, signed a contract whereby NevadaCare agreed to provide group health insurance to those M & K employees who chose it as their carrier. During the open enrollment period, Ms. Simkins selected NevadaCare.

NevadaCare provided each new subscriber and enrolled dependent an Evidence of Coverage ("EOC") booklet describing the covered benefits. Part IV of the EOC, Services and Benefits Within the Managed Care Network, provides in part:

> R. Transplant Services
> Coverage is provided for the Medically Necessary services required for human tissue and organ transplants, for the treatment of non-occupational disease or injury. All transplant related services must be pre-

authorized by the NevadaCare Medical Director.

1. Organ transplants for heart, kidney, cornea and liver. Liver transplant limited to that required as a result of biliary atresia only.

2. Tissue transplant coverage is limited to allogenic bone marrow only.

Part VI, Exclusions, Limitations and Non-Covered Services, likewise provides:

31. We will cover services for covered organ transplant expenses, as defined below, incurred by a Member for an organ transplant approved by Us at a facility approved by Us, subject to those conditions and limitations described below. Transplant means pre-transplant, transplant and post-discharge services, and treatment of complications after transplantation. We will cover only services, care and treatment received for or in connection with the approved transplantation of the following human organs:

    1. Heart, Kidney, Cornea, and Liver. Liver transplant limited to that required as a result of biliary atresia only.

    2. Tissue transplant coverage is limited to allogenic bone marrow only.

Part VI, Exclusions, Limitations and Non-Covered Services also specifically excludes from coverage "[a]ny services or supplies not specifically listed in this Evidence of Coverage as covered benefits, services, or supplies.

Finally, Part XI, Member Rights and Responsibilities, states in part:

> D. Complaint and Grievance Procedure. You have the right to express Your concerns and problems regarding Your NevadaCare coverage and benefits. You are encouraged to contact Member Services with any questions or problems as soon as they arise. NevadaCare is committed to providing prompt and responsive service to all Members.
>
> If you are unhappy with the answer You receive, You can tell the Member Services Representative You wish to file a grievance. It must be filed no later than thirty (30) working days after the date of the action, decision, or incident with which You are unhappy.
>
> NevadaCare will make a final decision for grievance about medical care services within fifteen (15) days of receiving written or oral grievance. A letter will be mailed to You stating NevadaCare's decision and the reason for the decision. The letter will tell You how You can appeal the decision if You are not satisfied. You must let NevadaCare know if You want to appeal the decision.
>
> If You are appealing the decision, You must submit a written appeal to NevadaCare no later than fifteen (15) days from the date of the final decision. The grievance coordinator will send Your request for appeal to the QM/UM committee.

Shortly after enrolling with NevadaCare, Ms. Simkins consulted her family physician because she felt dizzy and weak. After an X-ray and a CAT scan, her doctor discovered that she had nodules in her lungs and a mass on her liver. Based on these findings, her oncologist opined that the cancer had metastasized.

Ms. Simkins' treating physicians referred her to the UCLA Medical Center. There, Dr. John Glaspy recommended that she undergo the high dose chemotherapy with peripheral stem cell rescue ("HDC/PSCR") procedure. HDC/PSCR is a multi-stage procedure designed to treat breast cancer with the highest possible success rate. First, the patient is given injections in order to multiply the rate of production of stem cells in her blood stream. Next, the physician extracts the cancer patient's white blood cells from her blood stream, to "harvest" the necessary number of cell stems for transplant. The harvesting normally takes three to four days. Once the requisite number of cell stems have been harvested, they are frozen and stored until after the high dose chemotherapy is administered. Afterwards, the patient undergoes several days of high-dose chemotherapy. These high doses of chemotherapy, which can be up to several hundred times the normal dosage, eradicate cancer cells, but also destroy a considerable portion of the patient's other cells. Normally, the high level of chemotherapy would prove fatal to the patient, as the patient is very susceptible to opportunistic infections due to the eradicating effects of the high chemotherapy levels. Therefore, in order to "rescue" the patient after the high dose chemotherapy is complete, the patient's own previously harvested and stored cell stems are infused into her bones and immune

functions are restored, thereby minimizing the toxic effects of the high dose chemotherapy and avoiding the otherwise lethal effects of such high doses. Finally, the physician must carefully monitor the patient's growth and multiplication of stem cells to ensure recovery.

On April 3, 1998, UCLA Medical Center's Bone Marrow Transplant Insurance Coordinator requested written authorization from NevadaCare to cover Ms. Simkins's HDC/PSCR treatment. NevadaCare denied coverage on April 30, 1998, stating:

> This letter is to inform you of the following: The requested services for a autologous bone marrow transplant for Ruby Simkins has been reviewed and denied as a noncovered benefit. The NevadaCare evidence of coverage (EOC), which you received at the time of enrollment outlines the benefits of transplant services and specifically states that tissue transplant coverage is limited to allogenic bone marrow only. This denial of benefits is a denial of plan coverage and is not related to the medical necessity, per the diagnosis.

An autologous transplant is one involving tissue "derived from the same individual." *Webster's Third New International Dictionary* 148 (1986). An allogenic transplant, on the other hand, requires material from an external source, such as another person. *Id.* at 57.

Ms. Simkins subsequently underwent the HDC/PSCR procedure in July 1998, at the expense of M & K.[1] Believing that NevadaCare improperly denied coverage,

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[1] M & K is owned by Ms. Simkins' husband, Louis Simkins.

Ms. Simkins and M & K filed a Complaint on August 7, 1998.[2] Plaintiffs' Complaint asserts six causes of action: (1) declaratory relief pursuant to 29 U.S.C. § 1132 (a)(1)(B); (2) permanent injunction; (3) breach of contract/ plan; (4) breach of fiduciary duty; (5) breach of implied covenant of good faith and fair dealing; (6) failure to provide information. On November 9, 1998, Plaintiffs filed a Motion for Permanent Injunction and Motion for Partial Summary Judgment. NevadaCare responded by filing its own Motion for Summary Judgment on December 8, 1998.

STANDARD OF REVIEW

Pursuant to Federal Rule of Civil Procedure 56, summary judgment is proper "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c). All facts and inferences drawn must be viewed in the light most favorable to the responding party when determining whether a genuine issue of material fact exists for summary judgment purposes. *Brinson v. Linda Rose Joint Venture*, 53 F.3d 1044, 1050 (9th Cir. 1995). A material issue of fact is one that affects the outcome of the litigation and requires a trial to resolve the differing versions of the truth. *S.E.C. v. Seaboard Corp.*, 677 F.2d 1301, 1305-06 (9th Cir. 1982). The substantive law defines

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[2] Ms. Simkins did not seek, and NevadaCare did not insist upon, administrative review of NevadaCare's decision pursuant to Part XI of the EOC.

which facts are material. *Anderson v. Liberty Lobby*, 477 U.S 242, 248 (1986). A genuine issue of material fact requires more than some "metaphysical doubt" as to the material facts. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986). Only disputes over outcome determinative facts under the applicable substantive law will preclude the entry of summary judgment. *Id.* If the factual context makes the respondent's claim implausible, that party must come forward with more persuasive evidence than would otherwise be necessary to show that there is a genuine issue for trial. *Celotex Corp. v. Catrett*, 477 U.S. 317, 323-24 (1986).

The party moving for summary judgment has the initial burden of showing the absence of a genuine issue of material fact. *Metro Indus., Inc. v. Sammi Corp.*, 82 F.3d 839, 847 (9th Cir.), *cert. denied*, 519 U.S. 868 (1996). Once the movant's burden is met by presenting evidence which, if uncontroverted, would entitle the movant to a directed verdict at trial, the burden shifts to the respondent to set forth specific facts demonstrating that there is a genuine issue for trial. *Liberty Lobby*, 477 U.S. at 250. In meeting this burden, parties seeking to defeat summary judgment cannot stand on their pleadings once the movant has submitted affidavits or other similar materials. Affidavits that do not affirmatively demonstrate personal knowledge are insufficient. *Keenan v. Allan*, 91 F.3d 1275, 1278 (9th Cir. 1996).

The Supreme Court cases cited above establish that the "[s]ummary judgment procedure is properly regarded not as a disfavored procedural shortcut, but rather as an integral part of the Federal Rules as a whole, which are designed 'to secure the just, speedy and inexpensive

determination of every action.' " *Celotex Corp.*, 477 U.S. at 327 (quoting Fed. R. Civ. P. 1).

DISCUSSION

Because the crucial issue in both Plaintiffs' and NevadaCare's motions is whether NevadaCare's denial of coverage was improper, the court begins with this question. Both parties agree that the NevadaCare health plan is an employee welfare benefit plan under ERISA, 29 U.S.C. § 1001 *et seq.*

A denial of benefits challenged under 29 U.S.C. § 1132(a) (1) (B) is reviewed *de novo* "unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan," in which case an abuse of discretion standard is applied. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989).

In this case, NevadaCare urges the court to apply the abuse of discretion standard because it contends that the following language reserves to it discretionary authority to determine eligibility for benefits or to construe the terms of the plan:

> **Medically Necessary** – The use of services and/or supplies, as described in this Evidence of Coverage, which are required to identify or treat Your illness or injury and which are:
>
> 1. consistent with the symptoms or diagnosis and treatment of Your condition, disease, ailment or injury;
>
> 2. appropriate, safe, and effective with regard to standards of good medical practice;

3. not solely for Your convenience, Your Physician, Hospital or other health care provider;

4. consistent with the most appropriate supply of level of service which can be safely provided to You. When applied to an inpatient, it further means that Your medical symptoms or condition require that the diagnosis or treatment cannot be safely provided to You as an outpatient; and

5. consistent with medical policy and procedure as defined by the NevadaCare Quality Management Program.

Prior/Pre-Authorization. That a Participating Provider or Physician must receive approval from an authorized staff member of NevadaCare, such as the Medical Director or his designee, before You can receive certain health care services.

Complaint and Grievance Procedure

* * *

NevadaCare will make a final decision for grievance about medical care services within fifteen (15) days of receiving written or oral grievance. A letter will be mailed to You stating NevadaCare's decision and the reason for the decision. The letter will tell You how You can appeal the decision if You are not satisfied. You must let NevadaCare know if You want to appeal the decision. (Emphasis added by NevadaCare).

The language in the EOC expressly vests NevadaCare with the authority to define "medical policy and procedure." Moreover, NevadaCare is responsible for making final decisions regarding coverage and benefits.

Plaintiffs contend that even if the court concludes that the plan's language confers on NevadaCare the requisite authority to determine eligibility and interpret the terms in the plan, the *de novo* standard of review still applies. According to Plaintiffs, in cases where the insurer has both the decision-making authority and a financial interest in not paying, the insurer's actions must be viewed more skeptically. The Ninth Circuit squarely addressed this issue in both *Lang v. Long-Term Disability Plan*, 125 F.3d 794 (9th Cir. 1997), and *Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1322 (9th Cir. 1995):

> [W]e must review the decisions of an apparently conflicted employer- or insurer-fiduciary under the traditional abuse of discretion standard unless it appears the conflict may have influenced the decision. To make such a showing, the affected beneficiary must come forward with "material, probative evidence, beyond the mere fact of the apparent conflict, tending to show that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the beneficiary." *Atwood*, 45 F.3d at 1322. If the beneficiary satisfies the burden, our review remains for abuse of discretion, but it becomes "less deferential." *See Snow v. Standard Ins. Co.*, 87 F.3d 327, 331 (9th Cir. 1996) (citing *Atwood*, 45 F.3d at 1322.).

Lang, 125 F.3d at 798. Because Plaintiffs have not come forward with "material, probative evidence, beyond the

mere fact of the apparent conflict" tending to show that NevadaCare's self-interest caused a breach of its fiduciary obligations to Ms. Simkins, the court will apply the abuse of discretion standard.[3]

An ERISA plan administrator abuses her discretion when she makes a decision without any explanation, or in a way that conflicts with the plain language of the plan, or that is based upon clearly erroneous findings of fact. *Taft v. Equitable Life Assurance Soc'y*, 9 F.3d 1469, 1472-73 (9th Cir. 1994). The court inquires "not into whose interpretation of the plan documents is most persuasive, but whether the plan administrator's interpretation is unreasonable." *Barnett v. Kaiser Found. Health Plan, Inc.*, 32 F.3d 413, 416 (9th Cir. 1994) (quotation and brackets omitted); *see also Winters v. Costco Wholesale Corp.*, 49 F.3d 550, 552 (9th Cir. 1995).

Plaintiffs argue that NevadaCare should not have denied coverage for Ms. Simkins' HDC/PSCR procedure because it is not an organ transplant, it is not a bone marrow transplant, and it is not specifically listed as a

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[3] Some cases state that an "arbitrary and capricious" standard is applied, while others use the term "abuse of discretion." *Compare Eley v. Boeing Co.*, 945 F.2d 276, 278-79 (9th Cir. 1991) ("abuse of discretion") *with Dytrt v. Mountain State Tel. & Tel. Co.*, 921 F.2d 889, 894 (9th Cir. 1990) ("arbitrary and capricious"). The standards differ in name only. *See Barnett v. Kaiser Found. Health Plan, Inc.*, 32 F.3d 413, 415 (9th Cir. 1994). In *Firestone*, the Supreme Court focused on whether the administrator had "discretionary authority." 489 U.S. at 115. The court will therefore use the "abuse of discretion" terminology as well.

non-covered service. Plaintiffs' organ transplant argument focuses on Paragraph 31 of Part VI of the EOC:

> 31. We will cover services for covered organ transplant expenses, as defined below, incurred by a member for an organ transplant approved by us, subject to those conditions and limitations described below . . . We will cover only services, care and treatment received for or in connection with the approved transplantation of the following human organs:
>
> 1. Heart, Kidney, Cornea, and Liver. Liver transplant limited to that required as a result of billary [sic] atresia only.
>
> 2. Tissue transplant coverage is limited to allogenic bone marrow only.

Plaintiffs contend that this section is "unintelligible to any beneficiary seeking to determine coverage for the HDC/PSCR procedure" because the section discussing "tissue transplant coverage" is but a subsection of Paragraph 31, which refers generally to organ transplants. Thus, Plaintiffs state that "[a]ny reasonable beneficiary would read the exemption to apply only to 'organ' transplants." Following Plaintiffs' argument, Paragraph 31 would not apply to the HDC/PSCR procedure.

Assuming for purposes of this motion that Paragraph 31 does not exclude the HDC/PSCR procedure because it is limited to organ transplants, the court concludes that Paragraph R of Section IV of the EOC clearly pertains to tissue transplants:

R. Transplant Services

Coverage is provided for the Medically Necessary services required for *human tissue and organ transplants,* for the treatment of non-occupational disease or injury. All transplant related services must be pre-authorized by the NevadaCare Medical Directors.

1. Organ transplants for heart, kidney, cornea and liver. Liver transplant limited to that required as a result of biliary atresia only.

2. *Tissue transplant coverage is limited to allogenic bone marrow only.*

While Paragraph 31 may only apply to organ transplants, there is no doubt that Paragraph R pertains to both organ and tissue transplants. This leads the court to Plaintiffs' second argument, which is that the HDC/PSCR procedure is not a bone marrow transplant.

Plaintiffs vigorously argue that the HDC/PSCR procedure is separate and distinct from an autologous bone marrow transplant. Regardless of whether these are two different procedures, the undisputed evidence shows that they are both tissue transplants. Paragraph R specifically states that the *only* tissue transplant that is covered under Ms. Simkins' plan is an allogenic tissue transplant. Moreover, NevadaCare's April 30, 1998 letter reiterates that coverage for Ms. Simkins' procedures was denied because "tissue transplant coverage is limited to allogenic bone marrow only." Both parties agree that the HDC/PSCR procedure is autologous, rather than allogenic. Therefore, under either a *de novo* review, or an abuse of discretion review, the court concludes that the plain

unambiguous language of NevadaCare's EOC requires denial of coverage for Ms. Simkins' HDC/PSCR.

The court briefly addresses Plaintiffs' final argument that the HDC/PSCR procedure should be covered because it is not explicitly excluded from coverage. Plaintiffs apparently overlook the catch-all exclusion contained in Paragraph 29 of Part VI of the EOC. This paragraph specifically excludes from coverage "[a]ny services or supplies not specifically listed in this Evidence of Coverage as covered benefits, services, or supplies." Therefore, because HDC/PSCR is not specifically listed as a covered procedure, Paragraph 29 excludes it from coverage.

Of Plaintiffs' six causes of action, the first four (29 U.S.C. § 1132(a) (1) (B) declaratory relief; permanent injunction; breach of contract/plan; and breach of fiduciary duty) fail as a result of the court's conclusion that NevadaCare did not improperly deny coverage for Ms. Simkins's HDC/PSCR procedure. Plaintiffs admit that the fifth cause of action, a state law claim for breach of the implied covenant of good faith and fair dealing, is preempted by ERISA. Thus, the court need only address Plaintiffs' remaining cause of action for "failure to provide information."

29 U.S.C. § 1133(1) requires ERISA plan administrators to "provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant . . . " 29 C.F.R.

§ 2560.503-1(f) enumerates four items that must be included in each written notice:

1. The specific reason or reasons for the denial;
2. Specific reference to pertinent plan provisions on which the denial is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
4. Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review.

29 C.F.R. § 2560.503-1(f).

In this case, NevadaCare's April 3, 1998 letter denying coverage clearly meets the first two requirements. The letter states that Ms. Simkins' request was reviewed and denied as a noncovered benefit. The letter also refers to the section of the EOC outlining the benefits of transplant services and specifically states that tissue transplant coverage is limited to allogenic bone marrow only.

The court finds that NevadaCare met the third requirement by explaining in the letter that the denial of benefits "is a denial of plan coverage and is not related to the medical necessity, per the diagnosis." Thus, in this instance, unlike that where coverage depends upon a properly supported medical diagnosis, there is no additional material or information that Ms. Simkins could have submitted in order to perfect her claim.

Finally, the court also finds that NevadaCare's April 30, 1998 letter, combined with the EOC and subsequent

letters to Plaintiffs' counsel, met the fourth requirement of explaining the available review process. While the April 30, 1998 letter does not explain the review process in detail, it does provide a phone number to contact NevadaCare for additional information pertaining to the denial of benefits. In addition, the EOC that was issued to each plan subscriber upon enrollment contains detailed information regarding the complaint and grievance procedure. Moreover, in a May 26, 1998 letter to Plaintiff's counsel, NevadaCare forwarded a copy of the EOC and identified the relevant portions regarding the appeal process.

Consistent with other courts that have considered this issue, the court concludes that, as a matter of law, NevadaCare provided adequate written notice within the meaning of 29 U.S.C. § 1133 and 29 C.F.R. § 2560.503-1(f). *See Heller v. Fortis Benefits Ins. Co.*, 142 F.3d 487, 493 (D.C. Cir. 1998) (holding that although insurer never advised claimant of her right to appeal in its letter denying coverage, procedures followed were sufficient to meet purposes of statute in insuring that claimant understood reasons for denial, where, before she filed suit, claimant was informed of right to appeal); *Dade v. Sherwin-Williams Co.*, 128 F.3d 1135, 1142 (7th Cir. 1997) (holding that "substantial compliance" with ERISA notice requirements is sufficient; affirming summary judgment where defendant's two letters provided plaintiff with "sufficiently clear understanding of the administrator's position"); *Kent v. United of Omaha Life Ins. Co.*, 96 F.3d 803, 807 (6th Cir. 1996) ("When claim communications as a whole are sufficient to fulfill the purposes of Section 1133, the claim

decision will be upheld even if a particular communication does not meet those requirements.").

The issue presented in this case is not whether NevadaCare or any other insurer *should*, as a matter of sound public policy, provide coverage for procedures such as HDC/PSCR. The question here is whether, under the applicable terms of coverage, NevadaCare improperly denied coverage or otherwise breached its argument.[4] The court concludes it did not.

CONCLUSION

For the reasons stated above, the court DENIES Plaintiffs' Motion for Permanent Injunction and Motion for Partial Summary Judgment and GRANTS Defendant NevadaCare's Countermotion for Summary Judgment.

IT IS SO ORDERED.

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[4] The court notes that Congress is currently considering landmark health care legislation designed to address many of the concerns raised by Plaintiffs here. Until such legislation is passed, health care insurers are free to limit the providers and treatments that are covered by their plans, so long as such limitation is disclosed and accepted by the plan administrator. It is for Congress and the State legislators to carefully address matters of public policy in this area, not for federal courts to usurp their authority in an attempt to legislate from the bench no matter how strongly the court may feel about the particular case before it.

DATED: Honolulu, Hawaii, JUL 16 1999

/s/ David Alan Ezra
DAVID ALAN EZRA
CHIEF UNITED STATES
DISTRICT JUDGE

Ruby Simkins, et al. vs. Nevadacare, Inc., CV-S-98-01133-DAE(RJJ); ORDER DENYING PLAINTIFFS' MOTION FOR PERMANENT INJUNCTION AND MOTION FOR PARTIAL SUMMARY JUDGMENT; GRANTING DEFENDANT NEVADACARE'S COUNTERMOTION FOR SUMMARY JUDGMENT

Nevada Care
POS Evidence of Coverage

Triple Option Point Of Service

GROUP CONTRACT
EVIDENCE OF COVERAGE

This is Your Group Contract Evidence of Coverage with NevadaCare (herein referred to as "NevadaCare"), 1701 W. Charleston Blvd., Suite 420, Las Vegas, Nevada, 89102, (702) 474-7241 or 1-(800) 447-9834.

This Evidence of Coverage is provided to each Subscriber (and eligible enrolled family members) who has enrolled in NevadaCare through a Group Contract. This Evidence of Coverage and any attached papers, Your Enrollment Form and Identification Card become the contract between You and NevadaCare. By enrolling in NevadaCare and accepting this Evidence of Coverage, the Member agrees to abide by the rules as described in this Evidence of Coverage. Members are eligible to receive Medically Necessary services and benefits described in this Evidence of Coverage in exchange for the premium paid to NevadaCare.

NevadaCare is a health maintenance organization that offers you a comprehensive package of health care benefits.

If You have questions about this Evidence of Coverage, please call NevadaCare at the telephone number listed above. A Member Service Representative will be available to assist You.

[LOGO]NevadaCare

NevadaCare Triple Option Point Of Service Plan
Evidence of Coverage
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NevadaCare

Part I. Definitions

Acute – An illness or injury of short duration and generally of sudden onset and infrequent occurrence in which illness or injury is not always present.

Allowable Charges – The amount of billed charges defined by the Plan as the usual, customary and reasonable for the service provided. The contract rate for billed charges payable per contract agreement determine the usual, customary and reasonable fee when applicable.

Assignment of Benefits – Authorization by the covered person for benefits to be paid directly to the qualified care provider.

Birthing Center – A hospital unit or center, or free-standing facility, licensed in the jurisdiction in which it is located that provides a home-like setting under a controlled environment for the purpose of childbirth. After the birth, the infant and mother are examined and remain in recovery from four (4) to twenty-four (24) hours and then are permitted to return home. Emergency transportation services are also available in case an unforeseen complication arises either with the infant or the mother and an immediate transfer to a hospital becomes necessary.

Calendar Year - Any one (1) year period commencing on January 1, and ending December 31. However, when a person first becomes covered by the Plan, the first Calendar Year begins for him or her on the effective date of his or her coverage and ends on the following December 31.

Chronic – An illness or injury which is, or is expected to be, of long duration such as six (6) months or longer, and frequent recurrence and is always present to a greater or lessor [sic] degree.

Contribution – The amount (if any) deducted from an employee's paycheck, to pre-pay a portion of the cost of bearing the risk for providing benefit coverage.

Coordination of Benefits (COB) – Provision that defines the order in which benefits are paid when two or more plans provide coverage. The intent is to allow payment of

charges up to, but not over, 100% of the maximum allowable fee.

Copayment – The amount of money that each covered person may be required to pay before services and supplies are rendered.

Covered Services – Those services described in this Evidence of Coverage which, when Medically Necessary, are provided to Members.

Day/Ambulatory Surgery Center – A facility licensed to perform ambulatory surgery in the jurisdiction in which it is located that:

a. has an organized medical staff of physicians;

b. has permanent facilities equipped and operated primarily for the purpose of performing surgical procedures;

c. offers continuous physician services and registered professional nursing services whenever the patient is in the facility; and

d. generally, does not provide accommodations for patients to stay overnight, except that a hospital outpatient department will be considered a Day Surgery Center.

Dependent – Any member of the Subscriber's family who meets the eligibility requirements for coverage as described in Part III of this Evidence of Coverage and has been enrolled by the Subscriber.

Disabled – The incapacity of an eligible employee by reason of bodily injury or sickness that prevents the eligible employee from performing the material duties of his or her job with the employer.

Durable Medical Equipment – Equipment recognized as such by Medicare Part B, that meets all of the following criteria.

a. it can stand repeated use;

b. it is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience;

c. it is usually not useful to a person in the absence of sickness or injury;

d. it is appropriate for home use;

e. it is related to the patient's physical disorder;

f. it is for temporary use only; and

g. it is certified by a physician as being medically necessary.

Durable medical equipment includes, but is not limited to, such items as: hospital bed; wheelchair; iron lung; traction apparatus; intermittent positive pressure breathing machine; brace; and crutch.

Emergency – A medical condition requiring services that are furnished by a hospital or similar facility and;

a. are needed immediately because of a sudden illness or injury and;

b. the time required to reach an appropriate facility would have meant risk or permanent damage to the covered person's health e.g.: life threatening situations (such as real or apparent heart attack, severe bleeding, loss of consciousness and severe or multiple injuries).

Enrollee – An individual who has been voluntarily enrolled in a health care plan.

Evidence of Coverage – This document, any Riders, the Schedule of Benefits, and any amendments that may be added in the future, which explain the services and benefits covered by NevadaCare and defines the rights and responsibilities of the Member and NevadaCare.

Exclusion – An item or service which is not a benefit under this Evidence of Coverage.

Expenses of Charges Incurred – An expense that shall be deemed to be incurred on the date the purchase is made or the day the service is rendered for which the charge is made.

Grace Period – The thirty (30) day period from the date Premium payment is due until it is considered delinquent. During the Grace Period coverage remains in effect.

Group – The employer or other party that has entered into a Group Contract with NevadaCare through which this Evidence of Coverage is made available to eligible employees and the employer has agreed to collect and pay Premiums. The Group is not an agent of NevadaCare.

Group Contract – The agreement between the Group and NevadaCare through which the Health Plan coverage for eligible employees and Dependents is elected.

Group Open Enrollment Period – The period of time established by NevadaCare during which eligible persons who have not previously enrolled with NevadaCare may do so. Open enrollment is a special enrollment period for Managed Care Plans. This allows Members and their

Dependent(s) who were not previously enrolled to join the NevadaCare Managed Care Plan.

Health Plan – NevadaCare, a health maintenance organization, organized and operating pursuant to Chapter 695C, Nevada Revised Statutes, any amendments thereto and all other applicable provisions of the laws of the State of Nevada.

Home Health Care Agency – (a) A service or agency which holds a valid certificate of approval, or license, as a public home health care agency or (b) a Hospital holding a valid operating certificate authorizing it to provide home health care services or (c) an establishment approved as a home health care agency under Medicare.

Home Health Care Plan – A program for care and treatment of a sick or injured covered person in his or her home by a Home Health Care Agency. The program must be established by the covered person's attending physician. The physician must approve the program in writing prior to the date home health care services begin. The physician must also certify that confinement in a hospital or skilled nursing facility would be required if home care were not provided.

Hospice – A facility that offers a coordinated program of home care and inpatient care for a terminally ill patient and the patient's family. A terminally ill patient is someone who has a life expectancy of six (6) months or less, as certified in writing by the attending physician. The Hospice must be approved by the Plan as meeting established standards including any legal licensing requirements of the state of locality in which it operates.

Hospital – An institution which meets all of the following requirements:

a. it maintains permanent, full-time facilities for bed care of five (5) or more resident patients.

b. it has a licensed resident physician and surgeon in attendance.

c. it has facilities for major surgery.

d. it continuously provides 24 hour nursing services by registered graduate nurses.

e. it is operated lawfully in the jurisdiction where it is located.

f. it is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of injured and sick persons on a basis other than a rest home, nursing home, convalescent home, rehabilitation facility, sub-acute care facility, a place for the aged, or facility for treatment of drug addiction or alcoholism.

A licensed Birthing Center or an Ambulatory Surgical Center shall be considered a proper institution for the purposes of this definition. An "Extended Care Facility", as defined under the Medicare Law, will not be considered a Hospital.

Injury – Bodily injury caused by an accident and resulting directly, and independently of all other causes, a loss covered by this Plan when the loss began while coverage is in force for the covered person.

Inpatient – A stay for which at least one (1) day's room and board is charged.

Managed Care Plan – An approach to controlling utilization, quality and cost of medical care using a variety of cost-containment methods, with an emphasis on creating incentives for employees to choose less expensive treatments. This approach is designed to provide cost-effective health care without reducing quality of care or access to services.

Medical Director – A physician designated by NevadaCare to monitor appropriate utilization of health care services.

Medically Necessary – The use of services and/or supplies, as described in this Evidence of Coverage, which are required to identify or treat Your illness or injury and which are:

a. consistent with the symptoms or diagnosis and treatment of Your condition, disease, ailment or injury;

b. appropriate, safe, and effective with regard to standards of good medical practice;

c. not solely for Your convenience, Your Physician, Hospital, or other health care provider;

d. consistent with the most appropriate supply or level of service which can be safely provided to You. When applied to an inpatient, it further means that Your medical symptoms or condition require that the diagnosis or treatment cannot be safely provided to You as an outpatient; and

e. consistent with medical policy and procedure as defined by the NevadaCare Quality Management Program.

Member – Any Subscriber or eligible enrolled Dependents entitled to benefits under this Evidence of Coverage.

Nervous and Mental Disorder – A mental or nervous condition as defined by the American Psychiatric Association that shall include, but shall not be limited to, a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

Non-Emergency Admission – An inpatient admission not related to an accident or life threatening condition as determined by the Plan.

Out-of-Area Services – Those services provided outside of the NevadaCare Service Area. Managed Care and Preferred Provider Network Out-of-Area Services are limited to Emergency Services and other services which are arranged and authorized by the Primary Care Physician and NevadaCare.

Outpatient – Treatment not requiring inpatient confinement and not involving a charge for Room and Board.

Participating Provider – A health professional, a supplier of health care items, or a health care facility having an agreement with NevadaCare to provide medical services to NevadaCare Members.

Physician – A person who is licensed to administer medical care and treatment so long as the physician is acting within the scope of his or her practice and such license. A physician includes a surgeon and assistant surgeon.

Point of Services Plan – A Comprehensive benefit program composed of three (3) separate medical plans in one. The plan of benefits that is applicable is based on the

type of provider selected. Plan 1 benefits are payable when the member utilizes a Gatekeeper Primary Care Physician (PCP) and the Managed Care Network. Plan 2 benefits are payable when the member utilizes the Preferred Provider Network. Plan 3 benefits are payable when neither a Managed Care Provider or Preferred Provider is used. The Plan Member is free to choose any provider at any time, allowing for optimal choice. The Plan Member must select a Managed Care PCP provider to receive the maximum benefits and least out-of-pocket expense.

Premium – The periodic payment (usually monthly) made to NevadaCare by You, or on Your behalf, that entitles You to the benefits outlined in this Evidence of Coverage.

Prenatal Care – Care of the woman during the period of gestation. It consists of periodic examinations for determination of blood pressure, weight, changes in the size of the uterus, condition of the fetus, urinalysis, instruction in nutritional requirements, preparation for labor and delivery, care of the newborn; and provision of suggestions and support to deal with the discomforts of pregnancy. Scheduled visits at regular intervals offer the opportunity to monitor any changes in the condition of the mother and/or fetus to the necessary treatment can be instituted.

Primary Care Physician (PCP) – Family physician, internist or pediatrician who manges all day-to-day medical needs, all referrals to specialists and any necessary lab or Hospital services within the Managed Care Network.

Prior/Pre-Authorization – That a Participating Provider or Physician must receive approval from an authorized

staff member of NevadaCare, such as the Medical Director or his designee, before You receive certain health care services.

Provider – Any Physician, Hospital or other person who is licensed or otherwise authorized in this state to furnish health care services.

Service Area – Washoe and Clark Counties, Nevada.

Short Term – Therapy that is limited to treatment for conditions which are subject to significant clinical improvement within ninety (90) days of the start of treatment.

Sickness – A condition or an episode, other than injury, marked by pronounced deviation from the covered person's normal well state, causing loss covered by this Plan when the loss begins while coverage is in force or for the covered person.

Skilled Nursing Facility – A facility which is licensed by the State to provide inpatient medical and nursing care, is recognized as such by Medicare, and which has a contract with NevadaCare. Care in a Skilled Nursing Facility is provided only if hospitalization would otherwise be required. The term "Skilled Nursing Facility" does not include a convalescent nursing home, rest facility, or facility for the aged.

Subscriber – A person who meets all eligibility requirements and has completed an Enrollment Form and has paid, or has paid on his or her behalf, all applicable Premiums. The Subscriber is the person to whom this Evidence of Coverage is issued.

Supplemental Benefits or Riders – Additional or expanded benefits which are made available to the Group, subject to applicable underwriting requirements and Premium rates. Such Riders, when purchased by the Group, will be attached to and become a part of this Evidence of Coverage.

Terminally Ill Person – A covered person who has a life expectancy of six (6) months or less as certified by the covered person's physician.

Total Disability – Except where the context clearly indicates otherwise, means:

a. With respect to an employee, that he or she is prevented by reason of injury or sickness from engaging in each and every occupation or employment for wage or profit for which he or she is reasonably qualified by training, education or experience and he or she is under the regular care and attendance of a physician or surgeon.

b. With respect to a Dependent, that he or she is prevented by reason of injury or sickness from engaging in the normal or customary duties and activities of a person of like age and sex and is under the regular care and attendance of a physician or surgeon.

Usual, Customary and Reasonable Fee (UCR) – A "usual" fee is the fee usually charged, for a given service, by an individual physician to his or her private patient (his or her own usual fee) as determined by the Plan.

A "customary" fee is within the range of usual fees charged by physicians of similar training and experience,

for the same service within the same specific or limited geographic area as determined by the Plan.

A "reasonable" fee meets the above two criteria, or in the opinion of a duly constituted professional review panel organized by the local medical society where the services were rendered, is justifiable considering the special circumstances of the particular case in question.

Utilization Management (UM) – A process for evaluating the appropriateness, necessity, and quality of health care provided.

We or Us – Refers to NevadaCare.

You or Your – Refers to You (Subscriber/Member) and Your eligible enrolled Dependents (Members).

Part II. Plan Overview-Triple Option Point of Service Plan

The NevadaCare Triple Option Point of Service plan allows You to select one of three (3) options each time You obtain health care services. Each option differs in level of coverage and number of providers. You are free to choose the option that best fits Your health care and financial needs each time medical care is obtained. In order to receive the full value of Your NevadaCare Plan, it is important that You understand the terms, conditions and benefits of this Plan.

Regardless of which option You choose each time You receive health care, each Member must select a Primary Care Physician (PCP) from a list of Family Physicians, Internists and Pediatricians on the HMO Provider Directory. Each family member may select a different Primary

Care Physician. This selection is to be made during the enrollment period.

Managed Care Network Option (HMO) – Your Primary Care Physician is the coordinator of Your health care. He or She manages all day-to-day medical needs, all referrals to specialists or any lab or Hospital services You need. When You receive services from or are referred by Your PCP, You do not have to meet a deductible or pay any coinsurance. Instead, You pay a small fee (known as a copayment) for each service. The Plan pays 100% of the remaining charges. Using this option, You have claim forms to file and the cost to You is extremely affordable.

Preferred Provider Network Option (PPO) – This option allows You the freedom to bypass Your PCP and seek care directly from one of the many NevadaCare Preferred Providers. (Refer to Your NevadaCare Preferred Provider Directory.) When You use the Preferred Provider Option, many services including physician's office visits are available for a small copayment. To access other benefits, such as inpatient Hospital Services, You will need to satisfy an annual $250 deductible and then the Plan will pay 80% of Your charges.

Out-of-Network Option – This option works like a traditional indemnity plan and allows You the most flexibility in choosing a provider. Benefits are payable when neither a Managed Care or Preferred Provider is accessed. The total annual deductible for the Out-of-Network benefit is $500. Covered benefits are paid at 60% or 70% of the Usual, Customary and Reasonable (UCR) charges. Since providers that are outside of Our networks have not agreed to accept discounted rates, You will be responsible

for the amount a physician or facility may charge in excess of Our Usual, Customary and Reasonable rates. Claims incurred through the Out-of-Network option must be submitted with a claim form. Claim forms are available through Your Human Resources Department or You may request them from Our Member Services Department.

Annual deductibles for the Preferred Provider and Out-of-Network options are per person, three (3) deductible maximum per family per year. Pre-authorization is required. If pre-authorization is not obtained, no benefits will be payable under the HMO and benefits will be reduced by 50% on the PPO and Out-of-Network benefit levels. This is a summary only and not intended as a complete description of covered services.

Part III. Eligibility, Enrollment And Effective Date Of Coverage

A. Eligibility

1. Subscriber. To be eligible as a Subscriber You must:

   a. reside in the Service Area; or be employed within the Service Area;

   b. be a bona fide employee of the Group entitled to participate in the health care benefit program arranged by the Group or be entitled to coverage under a Trust Agreement or Employment Contract;

   c. satisfy any probationary or waiting period requirements established by Group; and

d. pay or have paid on Your behalf, all applicable Premiums.

2. Dependents. To be eligible to enroll as a Dependent the person must;

   a. reside with the Subscriber;

   b. meet all Dependent eligibility requirements established by the Group; and

   c. be the Subscriber's lawful Spouse; or

   d. be an unmarried child under the age of 19 who lives with You and who is primarily supported by You (extended to age 23 if student rider is attached). The term child includes natural children, step-children, children for whom You are legal guardian, or children who have been legally adopted or are waiting finalization of adoption by You, but does not include Your grandchildren; or

   e. be an unmarried child who is and continues to be both (1) unable to support himself or herself due to mental illness, developmental disability, mental retardation, or physical handicap and (2) chiefly dependent upon the Subscriber for support and maintenance. This condition must have occurred before the child reached age 19. Proof of the incapacity must be furnished to NevadaCare at the time of enrollment and each year thereafter.

3. Any person not defined in Part III. A-2. and B. is ineligible to be covered as a Dependent. Non-eligible persons include a foster child, a child placed in the Subscriber's home (except those placed for adoption), a granchild [sic] of Subscriber or Subscriber's spouse, an emancipated minor (as defined by Nevada law) and legal

wards (except those legal wards permanently placed in Subscriber's home by court order).

B. Enrollment

No person meeting Subscriber or Dependent eligibility requirements will be refused enrollment or re-enrollment by NevadaCare because of health condition, age, need for health services, or a pre-existing physical or mental condition, including pregnancy. You will not be eligible to re-enroll if Your coverage has been terminated under Part VIII of this Evidence of Coverage, however.

1. Initial Enrollment. As an employee of the Group, You are entitled to apply for coverage for Yourself and Your eligible Dependents during the initial Group Open Enrollment Period. All persons included for coverage must be listed on the Enrollment Form provided.

2. Group Open Enrollment. Open enrollment is a special enrollment period for Managed Care Plans. This allows members and their Dependent(s) who were not previously enrolled to join the NevadaCare Point of Service Plan. A Group Open Enrollment Period shall be held in the month preceding the renewal date at which time You may enroll as Subscriber and/or Members of NevadaCare. No proof of insurability will be required.

3. Newly Eligible Employees. As a new employee of the Group who becomes eligible for coverage at a time which is not Open Enrollment, You may enroll Yourself and Your eligible Dependents within thirty-one (31) days of becoming eligible.

4. Newly Eligible Dependents. You may enroll a person who becomes eligible as a Dependent by

completing and submitting to NevadaCare a signed enrollment form within thirty-one (31) days of becoming eligible.

a. newborn children will be covered from the date of birth for thirty-one (31) days. Coverage beyond the 31st day will be provided only if the newborn is enrolled within the first thirty-one (31) days following birth.

b. adopted children as of the date the adoption becomes effective, or the date the child is placed in the home, whichever occurs first. Certification by the adoption agency will be required.

5. Limitation. Persons initially or newly eligible for enrollment who do not enroll within thirty-one (31) days of eligibility may only be enrolled during the next Group Open Enrollment Period.

6. Notice of Ineligibility. It is Your responsibility to notify NevadaCare of any changes which will affect Your eligibility or the eligibility of Your Dependents within thirty-one (31) days of the event.

C. Effective Date of Coverage

After NevadaCare receives a completed Enrollment Form and the appropriate Premium arrangements are made, coverage under this Evidence of Coverage shall begin on the earliest of the following dates:

1. Initial Enrollment and Open Enrollment. Coverage shall begin on the date agreed upon by the Group and NevadaCare.

2. Newly Eligible Employees. Coverage will begin on the first day of the month following enrollment.

3. Newly Eligible Dependents. Coverage will begin on the first of the month following an event such as marriage, adoption and birth. Payments of the required charge, if any, must be furnished to the health maintenance organization within thirty-one (31) days after the date of birth, adoption or placement for adoption in order to have the coverage continue beyond the 31-day period.

4. The Effective Date of Coverage as noted in 1. through 3. above, may be changed by agreement of the Group and NevadaCare.

5. Delivery of Evidence of Coverage. NevadaCare will provide You with an Evidence of Coverage and other Member materials upon enrollment.

Part IV. Services And Benefits Within The Managed Care Network

You are eligible to receive the following medical care and services of doctors and other providers including medical, surgical, diagnostic, therapeutic and preventive services which are generally and customarily provided within the Managed Care Network. These services must also be determined to be Medically Necessary. As a Member of a managed care program, You and Your Primary Care Physician must work together. Your Primary Care Physician has accepted responsibility to provide, coordinate and arrange Your health care services.

Each Member must select a Primary Care Physician from a list of family physicians, internists and pediatricians. Each family member may select a different Primary Care Physician. This selection is made during the open enrollment period.

Except in an emergency as described in Section H. of this Evidence of Coverage, ONLY Managed Care Network services which are performed, prescribed, directed or authorized by Your Primary Care Physician or approved in advance by NevadaCare are covered benefits.

Services which are received without authorization or are rendered by a provider who is not under contract with NevadaCare may result in no benefit and payment may be Your responsibility.

Your Primary Care Physician (PCP) is the coordinator of Your health care. He or She manages all day-to-day medical needs, all referrals to specialists and any lab or Hospital services You need. When You receive services from or are referred by Your PCP, You do not have to meet a deductible or pay any coinsurance. Instead, You pay a small fee (known as a copayment) for each service. The Plan pays 100% of the remaining charges.

Some services require You to make a Copayment to the provider. Copayments must be made at the time the services are received. Copayment amounts are included in the Summary of Benefits which is attached.

A. Professional Services

You must select a Primary Care Physician who will provide, arrange and manage Your health care needs within the Managed Care Network. Benefits are maximized by utilizing Your PCP (Primary Care Physician).

1. Physician Office Visits. Services are provided for the diagnosis and treatment of illness or injury

when provided in the medical office of the Primary Care Physician or an authorized Specialty Physician.

2. Physician Hospital and Skilled Nursing Visits. Services of Health Plan Physicians for diagnosis, treatment and consultation are provided while You are an inpatient for authorized Hospital or skilled nursing services and/or emergency care as described in this Evidence of Coverage.

3. Physician Home Visits. Medically Necessary home visits are provided by Plan Physicians when the nature of the illness or injury so indicates.

4. Other Provider Home Visits. Care in the home by health care professionals, including but not limited to nurses, physical therapists, respiratory therapists, speech therapists, occupational therapists and others, are a covered benefit. These services are covered when prescribed and authorized or ordered by Your Primary Care Physician. This benefit is limited to a maximum of forty (40) total visits per Member per Calendar Year.

B. Hospital Services

All Hospital services must be pre-authorized and arranged by Your Primary Care Physician, except as described under Part III of this Evidence of Coverage for Emergency Services.

1. Inpatient Services. Coverage is provided for the following inpatient services which are medically necessary and when provided, arranged or authorized by a Plan Physician:

a. Semi-private room and board, with no limit to number of days except as described in this Evidence of Coverage for Mental Health

Inpatient Services and Alcohol and Substance Abuse Inpatient Services.

b. Inpatient Physician Services.

c. Private rooms are covered only when Medically necessary. They are only covered when authorized by a Plan Physician and approved by NevadaCare.

d. Laboratory, x-ray, and other diagnostic services.

e. Drugs, medications, biologics and their administration.

f. Use of operating and delivery rooms and related facilities.

g. Anesthesia and oxygen services.

h. Physical therapy and other rehabilitation services required as part of a Medically Necessary Hospital stay. Coverage is limited to services which are anticipated to result in significant clinical improvement within a reasonable period of time.

i. Radiation therapy, chemotherapy, and dialysis.

j. Blood and blood plasma and their administration.

2. Outpatient Services. Coverage for services provided through a Hospital outpatient department is provided, when Medically Necessary and authorized by a Plan Physician for the following services:

a. Radiation therapy, chemotherapy and dialysis.

b. Short-term rehabilitation services, limited to services which result in significant clinical improvement within a reasonable period of time.

c. Outpatient surgery which is Medically necessary and authorized by NevadaCare.

These services are subject to the limitations described in this Evidence of Coverage and any applicable Copayments required for certain services.

C. Laboratory and X-Ray Services

Prescribed laboratory and radiographic procedures, services and materials, including diagnostic x-rays; x-ray therapy, chemotherapy, fluoroscopy, mammography screening for occult breast disease, electrocardiograms, laboratory tests and therapeutic radiology services are provided when ordered, authorized or arranged by a Plan Physician. These services may be provided in an inpatient or outpatient setting, as ordered by the Plan Physician.

D. Maternity Services

1. Maternity Care. Coverage is provided for maternity care including pre- and postnatal care; use of Hospital delivery rooms and related facilities; use of newborn nursery and related facilities; special procedures as may be Medically Necessary and authorized by Plan Physician.

2. Newborn Care. Care of Your newborn child will be provided by a Plan Physician from the time of birth for thirty-one (31) days. Coverage beyond thirty-one (31) days requires the child to be enrolled within thirty-one (31) days from the date of birth.

E. Short Term Rehabilitation Services

Rehabilitation therapy including speech therapy, physical therapy, and occupational therapy is provided on a Short Term outpatient basis when prescribed by a Plan Physician. Therapy is limited to treatment for conditions which, in the judgement of the Plan Physician, are subject to significant clinical improvement within a reasonable period of time, ninety (90) days from commencement of services.

F. Mental Health Services

1. Inpatient Mental Services. Coverage is provided for medically necessary Inpatient Mental Health services, including Professional Services, when authorized by a Plan Physician and rendered in a NevadaCare approved facility. Services are limited to a maximum of sixty (60) inpatient days per Member per Calendar Year. You may convert inpatient days to cover mental health day treatment. For the conversion, one (1) inpatient mental health day is equal to two (2) days of service in an approved mental health day treatment facility.

2. Outpatient Mental Health Services. Coverage is provided for outpatient mental health services for crisis intervention and short-term evaluative services when authorized by NevadaCare. Coverage is limited to twenty (20) visits per Member per Calendar Year.

G. Alcohol and Drug Abuse Services

1. Outpatient Coverage is provided for treatment related to the withdrawal from alcohol or drugs, based on medical necessity as determined by NevadaCare. Treatment is limited to a maximum benefit of $1,500 per Member per Calendar year.

2. Inpatient Coverage is provided for alcohol or drug abuse for persons admitted by a Plan Physician and when rendered in a NevadaCare approved facility. Treatment for a patient admitted to a facility is limited to a maximum benefit of $9,000 per Member per Calendar year.

3. Coverage is provided for counseling of a Person, group or family who is not admitted to a facility and a medical need is determined by NevadaCare or its designated provider. Counseling services are limited to a maximum benefit of $2,500 per Member per Calendar Year.

4. The maximum amount which may be paid in the lifetime of the insured, for any combination of the treatments listed above is $39,000.

H. Emergency Care Services

As with all benefits under this Evidence of Coverage, Emergency Services must be provided or authorized by Plan Physicians unless time or circumstances make it impossible. You must notify NevadaCare or Your Primary Care Physician within 24 hours or as soon as reasonably possible after an emergency visit. Your Primary Care Physician provides 24-hour/day, 365 days/year coverage.

1. Coverage is provided for emergency care resulting from illness or injury which, if immediate care is not received (within 24 hours of illness and 72 hours from accidental injury) could be expected to result in long-term or permanent disability or loss of life.

2. You should ALWAYS contact Your Primary Care Physician within 24 hours, or as soon as reasonably possible if Prior Authorization was not received.

3. Emergency care services provided by non-contracted providers will be covered for services described herein. Such coverage is based upon the signs and symptoms presented at the time of treatment as documented by the attending doctor.

4. Managed Care Network Out-of-Area coverage is provided only for Emergency Services as described in this Evidence of Coverage. Level of benefits for Out-of-Area elective, routine or specialized care would vary based on criteria such as referral and prior authorization of services.

5. If You are hospitalized for emergency care in a non-contracted hospital or Out-of-Area hospital, NevadaCare may require that You be transferred to a contracted Hospital or other facility within the Service Area as soon as medically possible, should You choose to maximize Your health benefit.

I. Ambulance Services / Emergency Air Transport

1. Medically Necessary ambulance services are provided within the Service Area when used to transport the Covered Person from the place where he or she is stricken by an injury or sickness to the nearest Hospital where treatment can be given. In the case of sickness, an inpatient admission must occur in order for ambulance service to be covered.

2. Emergency ambulance service is a covered benefit when the ambulance is ordered for an emergency that could jeopardize Your health. Ambulance service will be covered when ordered by an employer, school or public safety official, or when You are not in a position to refuse the services.

J. Durable Medical Equipment

Durable Medical Equipment (DME) is medical equipment which can stand repeated use; is primarily and usually used to serve a medical purpose and is generally not useful to You in the absence of illness or injury.

1. Coverage is provided for DME as prescribed and authorized by a Plan Physician.

2. DME must meet the State of Nevada Medicaid guidelines, and must be provided as a result of Medical Necessity, not for Your convenience.

3. Repair, replacement and maintenance of authorized DME will be covered. Coverage is limited to normal wear and use and both growth/change. There is no coverage for equipment which has been abused or improperly cared for.

K. Prosthetic and Orthotic Devices

1. Prosthetic devices which aide body functioning or replace a limb or body part after accidental or surgical loss to correct a defect of body form and function are a benefit. Benefits are provided only for the basic prosthetic and any Medically Necessary special features prescribed by the Plan Physician.

   Prosthetic devices are limited to artificial limbs or eyes, orthopedic braces and supports which are custom-made for You. Specifically not covered are: custom fitted devices, special shoes, insoles, corsets, trusser or appliance and devices used to treat dental Temporomandibular Joint (TMJ) conditions, and all other devices.

2. Orthotics and artificial aids, such as cardiac pacemakers and artificial heart valves are a covered

benefit when authorized as Medically Necessary by the Plan Physician.

3. The appliance must be a prosthetic or orthotic device as defined by the State of Nevada Medicaid DME guidelines.

4. Benefits are provided for the initial prescription lenses (eye glasses or contact lenses) following an operation for cataract or diseases of the eye.

5. Benefits are provided for breast prosthesis required as a result of mastectomy. This benefit is limited to two (2) prostheses.

L. Skilled Nursing Facility Services

Coverage is provided for Skilled Nursing Facility services when Medically Necessary and authorized by a Plan Physician.

1. Coverage is provided for care in a Skilled Nursing Facility, provided the skilled nursing services are of a temporary nature and lead to rehabilitation and increased ability to function.

2. Custodial or domiciliary care is not a covered benefit.

3. If You remain in a Skilled Nursing Facility after discharge by the Plan Physician, or after the maximum benefit period is reached, You will be responsible for all associated costs for the services.

M. Dental Care Services

General dental services and dental services related to Temporomandibular Joint conditions (TMJ) are not covered benefit under this Evidence of Coverage; however, the following limited oral surgical procedures will be

provided in an inpatient or outpatient setting when approved by a Plan Physician:

1. Treatment for accidental injury to sound natural teeth, the jaw bones, or surrounding tissues. Treatment and repair must begin within fifteen (15) days of the date of a documented injury.

2. Treatment or correction of a non-dental physiological condition which has resulted in severe functional impairment.

3. Treatment of Temporomandibular Joint (TMJ) conditions is covered only for medical services, when such services are not recognized dental procedures. There is no coverage for dental appliances or dental devices used to treat TMJ condition.

4. Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of the mouth are covered.

N. Health Maintenance and Preventative Services

1. Periodic health assessments for adults, based upon nationally recommended guidelines relative to age, sex and medical history, are provided subject to applicable Copayments.

2. Annual gynecological examination and cytologic screening for females age 18 and over.

3. Baseline mammography for females ages 35 to 39, and annual mammography for females 40 and over.

4. Well child visits, including vision and hearing screening are provided through age 6.

5. Vision and hearing screening through age 17 to determine the need for vision and hearing correction.

6. Immunizations and vaccinations according to generally accepted medical practice standards, subject to applicable Copayments.

O. Plastic and Reconstructive Surgery

Plastic and Reconstructive Surgery is covered when:

1. Reconstructive surgery is incidental to or follows surgery resulting from trauma, infection, or other diseases of the involved part.

2. A congenital disease or anomaly has caused a functional defect, but only when the surgery is reasonable and expected to correct the condition.

3. Reconstructive surgery following a mastectomy on one or both breasts. The procedure includes but is not limited to augmentation mammoplasty, reduction mammoplasty and mastopexy.

P. Allergy Care

1. Coverage is provided for allergy testing and evaluation when provided by Your Primary Care Physician or an authorized Specialty Physician.

2. Coverage is provided for the preparation of Allergy serum when prepared by the Primary Care Physician or authorized Specialty Physician.

3. Allergy Injections are covered when provided by a Plan Physician.

Q. Hospice Care

A terminally ill Member is entitled to receive Hospice care. All care must be provided by a certified Hospice organization and must be approved by NevadaCare.

1. Care may be provided on an inpatient basis (in either a Hospice or a Hospital), or on an outpatient basis as determined by Your Primary Care Physician.

2. Coverage is provided for drugs and medical supplies provided by the Hospital or Hospice.

3. Coverage is provided for up to twelve (12) visits for bereavement counseling for family members, beginning on the death of the terminally ill Member.

4. A Member is considered terminally ill if the Primary Care Physician has certified the Member as having a life expectancy of six (6) months or less.

5. Outpatient coverage is provided for up to $2,000 in coverage per Calendar Year. Inpatient coverage is provided for up to $3,000 in coverage per Calendar Year.

R. Transplant Services

Coverage is provided for the Medically Necessary services required for human tissue and organ transplants, for the treatment of non-occupational disease or injury. All transplant related services must be pre-authorized by the NevadaCare Medical Director.

1. Organ transplants for heart, kidney, cornea, and liver. Liver transplant limited to that required as a result of biliary atresia only.

2. Tissue transplant coverage is limited to allogenic bone marrow only.

3. Coverage is provided for the necessary Hospital, surgical, laboratory, and x-ray expenses incurred by a donor for an authorized transplant to a

Member, unless the donor has coverage for such expenses.

Covered Expenses

For approved transplant procedures, and all related complications, We will cover only the following covered expenses:

1. Hospital expenses and physician's expenses will be covered under the same terms and conditions as We will cover care and treatment of any other covered injury or sickness, up to a maximum of $150,000 per transplant procedure.

2. Organ acquisition and donor cost. However, donor costs are not covered under the Group Plan if they are payable in whole or in part by any other group plan, insurance company, organization or person other than the donor's family or estate. In addition, We will not cover acquisition and donor costs related to the removal of an organ from a Member for the purpose of transplantation into a recipient who is not Our Member.

Part V. Services And Benefits Within The Preferred Provider And Out-of-Network Options

The Preferred Provider Network Option allows Members to bypass their Primary Care Physician and allows them access to a larger network of providers and Hospitals. The Plan Member may seek care directly from any of the participating health care providers within this network.

The Out-of-Network Option works like a traditional indemnity plan and allows the Member the most flexibility in choosing a provider. Benefits are payable when

neither a Managed Care or Preferred Provider is utilized. After the annual deductible is satisfied, the Plan will pay 60% or 70% of the Usual, Customary and Reasonable fee (UCR). The Member is responsible for the 30% or 40% coinsurance amount. Claims incurred through this option must be submitted with a claim form. Since providers under this option have not agreed to accept discounted rates, the Member will be responsible for the amount a physician or facility charges in excess of our Usual, Customary and Reasonable fee.

Please refer to Your Point of Service Summary of Benefits for further Plan information.

Part VI. Exclusions, Limitations And Non-Covered Services

A. Exclusions. Except as described under Part IV, Covered Benefits and Services, the following services are excluded from coverage under this Evidence of Coverage:

1. Under the Managed Care Network: Services of Non-Plan Provider, except in an Emergency. Out-of-Service Area benefits, except when authorized by NevadaCare or in an Emergency.

2. Any cosmetic surgery or procedure or any related Hospital services, except Medically Necessary reconstructive surgery which is incidental to or follows surgery resulting from trauma, infection or disease of the involved part, or which is needed to correct a congenital disease or anomaly of a covered Dependent which has resulted in a functional defect.

3. Any procedure or treatment designed to alter physical characteristics of the Member to those

of the opposite sex. Any other treatment or studies related to sex transformation.

4. Embryonic transfer, GIFT, in vitro fertilization and any related services for treatment of fertility or infertility conditions. Services for any person serving as a surrogate mother, and any services, treatments or procedures to induce or reverse voluntary elective sterilizations.

5. Services and procedures which have as a direct, and intended purpose the induction of abortion. This exclusion does not apply to medical complications arising out of any abortion or any treatment or procedure performed to save the life of a mother, even though it may result in the termination of the pregnancy.

6. Dental Care, including but not limited to treatment of the teeth, extraction of teeth, treatment of dental abscesses, treatment of gingival tissues (other than for tumors). Also excluded are dental examinations and any other dental product or service except as described under Part IV.M. of this Evidence of Coverage.

7. Care which, in the opinion of NevadaCare, is primarily for the rest or custodial purposes.

8. Any services or supplies furnished by a non-eligible institution, which is defined as other than a Hospital or Skilled Nursing Facility, and which is primarily a place of rest, a place for the aged, or nursing home, or any similar institution.

9. Alcohol and/or Substance Abuse services are not a benefit except as described under Part IV.G. of this Evidence of Coverage.

10. Personal comfort or convenience items.

11. Prescribed drugs and medications except as provided while confined as an inpatient, or take-home medication resulting from an inpatient admission.

12. Private duty nursing and private Hospital rooms, unless determined to be Medically Necessary by NevadaCare.

13. Hearing aids, or hearing exam and procedures for prescription or fitting of hearing aids. Corrective lenses and refractions. Surgical procedures to alter refractions. Procedures for prescription or fitting of corrective lenses except as provided under Part IV.K. of this Evidence of Coverage.

14. Physical examinations or immunizations when required for employment, insurance, licensing, marriage or travel which are not otherwise Medically Necessary.

15. Long-term mental health and psychiatric treatment. Services or treatment for mental retardation or Chronic mental illness. The monitoring of medications prescribed for such conditions. Enrollment in special schools, except as described under Part IV.F. of this Evidence of Coverage. Care and treatment of Chronic marital or family problems; social, occupational, religious, or other social maladjustments; Chronic behavior disorders; or Chronic situational reactions (for purposes of this exclusion and all other exclusions Chronic shall mean any condition existing for more than six (6) months).

16. Payment for services which would normally be provided without charge or services for which the Member would not otherwise be considered financially liable. Except for charges or services

from a government facility such as a V.A. Hospital which the member is eligible to receive benefits and the Plan must honor the charges, to the extent covered under this Evidence of Coverage.

17. Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, when such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

18. Routine foot care that is not Medically Necessary, including reduction of nails, calluses and corns.

19. Medical or Hospital services rendered on behalf of a donor or prospective donor when the recipient of an organ transplant is not a Member.

20. The cost of health services resulting from accidental bodily injuries to the extent such services are payable under any group insurance or other such liability coverage, by whatever terminology used, including such benefits mandated by law, excluding any automobile insurance policy.

21. Care in connection with the treatment of suicide, attempted suicide, or intentionally self-inflicted injury. This exclusion applies whether the Member is sane, insane, or while using illegal and/or controlled substances and/or alcohol.

22. Surgical and other procedures, for the treatment of obesity, or any complications arising there from, including but not limited to, Mason Shunt,

banding gastroplasty, or intestinal bypass. Special diet or food supplement programs or products, including but not limited to Nutri System, Optifast, etc.

23. Medical or hospital services provided as a result of injury sustained while in the act of committing a criminal offense or while being held by a law enforcement agency or while incarcerated.

24. Experimental medical, surgical or other procedures or treatments, including prescription medications. A procedure will no longer be deemed experimental when such procedure is consistent with accepted medical practice as determined by the National Institutes of Health or the Food and Drug Administration. Also, this exclusion will not apply when an item has been specifically identified as a basic health service requirement for all federally qualified or state certified health maintenance organization.

25. Services which are not Medically Necessary, except as expressly described in Part VI of the Evidence of Coverage. The final determination of Medical Necessity is the judgement of the Plan Physician with the concurrence of the NevadaCare Medical Director.

26. Speech therapy which is educational in nature and any other education services which are provided through the school district.

27. Pretrial or court testimony and the preparation of court related reports are not a benefit. Court ordered treatment for substance abuse or mental conditions is not a benefit except to the extent covered under this Evidence of Coverage and in accordance with policies and procedures for authorization of services.

28. Charges for care or services provided before the effective date after the termination of coverage under this Evidence of Coverage.

29. Any services or supplies not specifically listed in this Evidence of Coverage as covered benefits, services, or supplies.

30. Long-term physical therapy and rehabilitation for incurable conditions or Chronic, recurrent conditions for which rehabilitation produces minimal to zero and/or temporary change or relief.

31. We will cover services for covered organ transplant expenses, as defined below, incurred by a Member for an organ transplant approved by Us at a facility approved by Us, subject to those conditions and limitations described below. Transplant means pre-transplant, transplant and post-discharge services, and treatment of complications after transplantation. We will cover only services, care and treatment received for or in connection with the approved transplantation of the following human organs:

    1. Heart, Kidney, Cornea, and Liver. Liver transplant limited to that required as a result of biliary atresia only.

    2. Tissue transplant coverage is limited to allogenic bone marrow only.

    For a transplant procedure to be considered approved, prior approval from the company's Medical Director is required in advance of the procedure.

    Covered Expenses: For approved transplant procedures, and all related complications, We will cover only the following covered expenses:

1. Hospital expenses and physician's expenses will be covered under the same terms and conditions as We will cover care and treatment of any other covered injury or sickness, up to a maximum of $150,000 per transplant procedure.

2. Organ acquisition and donor cost. However, donor costs are not covered under the Group Plan if they are payable in whole or in part by any other Group Plan, insurance company, organization or person other than the donor's family or estate. In addition, We will not cover acquisition and donor costs related to the removal of an organ from a Member for the purpose of transplantation into a recipient who is not our Member.

B. Limitations. In the event that due to circumstances not within the control of the Health Plan, including but not limited to a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of the Plan Provider's personnel or similar causes, the rendering of Professional or Hospital Services provided under this Evidence of Coverage is delayed or rendered impractical, the Health Plan shall make a good faith effort to arrange for an alternative method of providing coverage. In such event, the Health Plan and Plan Providers shall render Hospital and Professional Services provided under this Evidence of Coverage insofar as practical, and according to their best judgement; but Health Plan and Plan Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Part VII. Plan Administration And Forms

A. Relationships of Parties. The relationship between NevadaCare and Plan Providers is that of an independent contractor relationship. Plan Providers are not agents or employees of NevadaCare or any of its employees, an employee or agent of Plan Providers. NevadaCare shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with , any injuries suffered by You while receiving care through any Plan Provider.

B. Patient/Provider Relationship. Plan Providers maintain a provider-patient relationship with You and are solely responsible to You for all health services. If You are unable to establish an acceptable patient-provider relationship You may request another Provider, and likewise Providers may request that You be transferred to another Provider.

C. Refusal to Accept Treatment. You may, for personal reasons, refuse to accept procedures or treatment by Plan Physician. Plan Physician may regard such refusal to accept recommendations as incompatible with continuance of the doctor-patient relationship. If no acceptable alternative exists for what the doctor believes to be proper medical care, You will be so advised. If You still refuse to accept the recommended treatment, neither NevadaCare nor the Plan Physician will be responsible for treatment of the condition or any services required as a result of refusal to accept treatment.

D. Premium Payment. The Premium charges for this Evidence of Coverage shall be determined by NevadaCare, subject to the approval of the applicable state regulatory agencies.

1. Premium payment is due on or before the first day of the month for which coverage is provided.

2. Only when Your Premium payment has been received are You entitled to health care services under this Evidence of Coverage. A Grace Period of thirty (30) days will be allowed.

E. Changes in Coverage or Premium. NevadaCare reserves the right to establish a revised Evidence of Coverage or revised Premium schedule as of each anniversary date of this Evidence of Coverage, in accordance with the applicable laws of the State of Nevada.

1. Upon at least sixty (60) days prior written notice to the Group, if the arrangement is approved by applicable regulatory agencies; or

2. If the amendment is accepted by the Group which acceptance shall be evidenced by the continued payment of charges after sixty (60) days notice.

F. Identification Cards. Identification Cards are issued for the purpose of identification only. If You willfully or knowingly permit another person to use Your Identification Card, no benefits will be paid for those services and Your coverage may be terminated.

Part VIII. Termination Of Coverage

A. Termination of Group Coverage. This Evidence of Coverage may be terminated in the following ways:

1. By the Group, for any reason, on the anniversary date of the Group Contract with thirty (30) days written notice to NevadaCare.

2. By NevadaCare if the Group fails to pay the Premium for this Evidence of Coverage when due, and if default continues after the Grace Period, the Group and all Members enrolled through the Group may be terminated.

3. By NevadaCare for any reason on file with the appropriate regulatory agencies upon thirty (30) days written notice.

4. By the Group, in writing, within ten (10) days of notice of increase in Premium.

B. Termination of Member Coverage. A Member's coverage may be terminated in the following ways:

1. By the Group if You are no longer eligible for Group coverage.

2. By NevadaCare for failure to make payment of Premiums or Copayments or other charges due Health Plan or Plan Providers.

3. By NevadaCare for attempted or committed fraud in submitting a claim for benefits or fraud in completing the initial application. NevadaCare may seek to recover the cost of any benefits obtained through fraud.

4. By Group, Member or NevadaCare if You permanently reside or move outside of the Service Area, subject to any applicable provisions provided in this Evidence of Coverage.

5. By Group, Subscriber or NevadaCare for any Dependent Member who is no longer eligible for Coverage as a Dependent.

6. By NevadaCare if You willfully and knowingly permit another person to use Your Identification Card.

7. By NevadaCare if You fail to cooperate with the administration of the Coordination of Benefits Program, outlined in Part X. of this Evidence of Coverage.

Part IX. Continuation Of Coverage

A. Termination of Group. Your benefits will cease as of the date of termination of coverage except as provided in this Part. In the event that coverage terminates because of termination of eligibility as described in Part VIII. of this Evidence of Coverage, all benefits will automatically cease. Coverage will continue for an authorized inpatient admission to a Hospital or Skilled Nursing Facility or for continuous total disability which began prior to the date of termination.

The extension of benefits will continue for the condition under treatment and causing total disability at the date of termination until whichever of the following events occurs first:

1. The disability is lifted, or You have been discharged as an inpatient; or
2. The maximum benefit period is reached; or
3. Your employment with the Group is terminated; or
4. A period of twelve (12) months from the date of termination has elapsed.

B. Federal Continuation. If Your coverage has been terminated under this Evidence of Coverage You may be eligible for coverage continuation under Federal requirements.

1. Federal Continuation. Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) You may be eligible for continuation of coverage under this Evidence of Coverage. This is provided that You have a qualifying event and elect to continue coverage within sixty (60) days

of the qualifying event. Qualifying events include:

a) termination of employment (other than for the reason of gross misconduct);

b) reduction in hours of employment;

c) death of Subscriber (covered employee);

d) divorce or legal separation from covered employee;

e) Subscriber becoming eligible for Medicare benefits;

f) loss of eligibility as a Dependent child under this Evidence of Coverage.

2. Continuation coverage will be for this Evidence of Coverage and will be at the Premium rate specified in the Group Contract, plus 2% for administration of the continuation. In no event shall the Premium exceed 102% of the specific Group Premium rate.

Continuation of coverage will end on the earliest of the following dates:

a) 18 months from the date continuation began as a result of employment termination or reduction in hours;

b) 18 months from the date continuation began as a result of total disability;

c) 36 months from the date continuation began as a result of the death of a Subscriber, divorce or legal separation from Subscriber, loss of Dependent status, or Subscriber's entitlement of Medicare;

d) 36 months from the date of the original qualifying event if a second qualifying event occurs;

e) the end of the period for which Premium has been paid if the Member falls [sic] to make Premium payments as specified by the Group;

f) the date the Member becomes covered under any other employer-sponsored group health plan;

g) the date the Member becomes entitled to Medicare; or

h) the date the Group Contract ends.

C. Small Group Continuation of coverage. If an employer who employs less than twenty (20) employees maintains a policy of group health insurance which covers those employees, the policy must contain a provision which permits:

1. An employee to elect to continue identical coverage under the policy, excluding coverage provided for eye or dental care if;

a) His or Her employment is terminated for any reason other than gross misconduct; or b) The number of his or her working hours is reduced so that he or she ceases to be eligible for coverage.

2. The spouse or Dependent child of an employee to elect to continue coverage, excluding coverage provided for eye or dental care if;

a) The employee's employment is terminated for any reason other than gross misconduct or the number of his or her working hours is reduced so that he or she ceases to be eligible for coverage; b) The employee dies; c) The

employee and his spouse are divorced or legally separated; d) The Dependent child ceases to be eligible for coverage under the terms of the policy; or e) The spouse ceases to be eligible for coverage after becoming eligible for Medicare.

3. The period of continued coverage is limited to:

   a) 18 months for an employee.

   b) 36 months for an employee's spouse or Dependent child.

4. An employee who voluntarily leaves his employment, or the spouse or Dependent child of the employee, is not eligible to continue coverage.

5. An employee, spouse or Dependent child who has not been covered under any group policy of employer for at least twelve (12) consecutive months before the termination of his or her coverage is not eligible to continue coverage.

6. An employee, spouse or dependent child shall notify the employer that he or she is eligible to continue his or her coverage not later than sixty (60) days after he/she becomes eligible to do so.

7. If the employee, spouse or Dependent child elects to continue coverage, he or she shall notify the Plan of his or her election and pay to the plan the premium required within sixty (60) days after receipt of the information.

8. Any person who elects to continue coverage shall pay the Premium for the coverage in an amount not to exceed 125% of the Premium charged to the employer by the Plan on the date on which that person becomes eligible for continued coverage.

9. The Premiums must be paid to the insurer on a quarterly basis.

10. If the payment of a Premium is not received by the insurer within thirty (30) days after the date on which it is due, continued coverage must be terminated.

11. If an employer changes plans during a period of a person's continued coverage, the new insurer shall provide continued coverage for that person for the remainder of the continuation period.

12. Continued coverage ceases before the end of the period provided if;

    a) The employer discontinues group health insurance for his or her employees;

    b) The employee, spouse or Dependent child fails to pay the required Premiums;

    c) The employee, spouse or Dependent child becomes covered under any other policy of group health insurance;

    d) The employee or spouse qualifies for Medicare; or

    e) The spouse remarries and becomes eligible for coverage under the new spouse's policy for group health insurance.

Part X. Coordination Of Benefits, Third Party Payments And Double Coverage

A. Nonduplication. NevadaCare will provide You with full health care services within the limits of this Evidence of Coverage. NevadaCare does not duplicate benefits or provide You with greater benefits than the actual expenses incurred. Benefits under

this Evidence of Coverage will be reduced to the extent that they are available or that reimbursement is payable under any other certificate or policy covering You whether or not a claim is made for the benefits.

B. Coordination of Benefits. It is not unusual that a person will be covered under two insurance contracts which provide similar coverage. If both of the contracts are issued through or by groups and if the service You receive is covered under both contracts, NevadaCare will coordinate benefit payments with the other company. One company will provide its full benefit as primary benefit. The other company will provide secondary benefits, if necessary, to the extent of its benefit. This prevents double payment and overpayment.

In order to determine which company is primary, these rules apply:

1. If the other contract does not have a provision similar to this one, then it is the primary contract.

2. If the person receiving the benefit is the Subscriber belonging to the group through which, or to which one contract was issued and is only covered as a Dependent on the other contract, the contract under which the person is the Subscriber shall be primary.

3. If two or more contracts cover the person receiving care as a Dependent, then the contract of the Subscriber whose birthday (month of birth) follows earliest in the Calendar Year shall be primary unless the other contract uses a rule based on the Subscriber's gender and as a result, the contracts do not agree on the order of benefits. In that case, the other contract shall be primary.

4. If the Dependent is the child of divorced or separated parents, then benefits for the child are determined in this order:

   1) first, the plan of the parent with custody of the child;

   2) then, the plan of the spouse of the parent with custody of the child;

   3) finally, the plan of the parent not having custody of the child; and

   Notwithstanding, a., b., and c., [sic] above, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefit of that plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which the benefits are actually paid or provided before the entity has that actual knowledge.

5. If none of the above applies, then the contract which has covered You or the person receiving services for the longest time shall be primary.

6. You are required to cooperate with NevadaCare in the administration of this provision. If this Evidence of Coverage requires that benefits be paid for by another source and You have failed to seek payment from that source, NevadaCare will reduce the payments under this Evidence of Coverage by the amount to which You are entitled from that source. In some cases NevadaCare may ask You to sign documents or cooperate with Us to seek payment from another source. You are required to cooperate in such cases.

7. NevadaCare will not pay for benefits under this Evidence of Coverage if coverage would be available to You under any government program, except Medicaid.

8. NevadaCare will not pay for services for students in college or similar educational institution which are provided by the school's health services unless the student's Primary Care Physician and NevadaCare have authorized such services in advance, except for emergency care described in Part IV.H. of this Evidence of Coverage.

9. None of the above rules as to coordination of benefits will serve as a barrier to You first receiving medical services through NevadaCare.

C. Subrogation. If You are injured or become ill through the act of a third party, NevadaCare will provide care for Your injury or sickness. When You accept these services You consent to the provisions of the Part X.B.1-4.

1. In the event of any payments for benefits provided to You, NevadaCare will be subrogated to all rights of recovery You have against any person or organization. NevadaCare shall be entitled to receive from any recovery an amount up to the amount paid by NevadaCare.

2. Any such right of subrogation or reimbursement provided to NevadaCare hereunder will not apply or will be limited to the extent that Nevada statutes or the courts of Nevada eliminate or restrict those rights.

3. NevadaCare will have a lien on all funds received by Member up to the amount paid or owed for the services and supplies provided and to be provided to You. NevadaCare may give

notice that lien to any party who may have contributed to the loss.

4. You are required to take any action, furnish such information and execute such instruments as NevadaCare may require to facilitate enforcement of its rights under this provision. If You fail to cooperate in administration of the Part, You may be responsible for the cost of the services and any legal costs incurred by NevadaCare to enforce its rights under this Part.

Part XI. Member Rights And Responsibilities

A. Confidentiality of Health Care Records. Information from Your medical records and information received from physicians or hospitals incidental to the doctor-patient or hospital-doctor relationship shall be kept confidential. Except for use incidental to bona fide medical research and education or reasonably necessary in connection with the administration of the NevadaCare program, such records may not be disclosed without Your consent.

B. Primary Care Physician. Every NevadaCare Member must have a Primary Care Physician. You have the right to select, to have selected on Your behalf, a Primary Care Physician from the NevadaCare Managed Care Network physician panel. Your Primary Care Physician has agreed to act as the coordinator of Your health care needs.

C. Explanation of Treatment. You have the right to have any treatment or diagnostic study explained to You by Your doctor prior to receiving treatment or undergoing diagnostic studies.

D. Complaint and Grievance Procedure. You have the right to express Your concerns and problems regarding Your NevadaCare coverage and benefits. You are

encouraged to contact Member Services with any questions or problems as soon as they arise. NevadaCare is committed to providing prompt and responsive service to all Members.

If you are unhappy with the answer You receive, You can tell the Member Services Representative You wish to file a grievance. It must be filed no later than thirty (30) working days after the date of the action, decision, or incident with which You are unhappy.

NevadaCare will make a final decision for grievance about medical care services within fifteen (15) days of receiving written or oral grievance. A letter will be mailed to You stating NevadaCare's decision and the reason for the decision. The letter will tell You how You can appeal the decision if You are not satisfied. You must let NevadaCare know if You want to appeal the decision.

If You are appealing the decision, You must submit a written appeal to NevadaCare no later than fifteen (15) days from the date of the final decision. The grievance coordinator will send Your request for appeal to the QM/UM committee.

E. Arbitration. Independent Medical Evaluation. In the event independent evaluation of the medical or chiropractic care is required in the final determination of benefits or care, the following is required:

1. Only a physician or chiropractor who is certified to practice in the same field of practice as the primary treating physician or chiropractor or who is formally educated in that field may conduct the independent evaluation.

2. The independent evaluation must include a physical examination of the patient, unless he or she is deceased, and a personal review of all x-rays

and reports by the primary treating physicians or chiropractor.

3. A certified copy of all reports of findings must be sent to the primary treating physician or chiropractor and the insured person within ten (10) working days after the evaluation.

If the insured person disagrees with the finding of the evaluation, he or she must submit an appeal to the insurer for binding arbitration within thirty (30) days after he or she receives the finding of the evaluation. Matters of continuing dispute shall be submitted to a Board of Arbitrators consisting of three (3) chosen and operating under the rules and regulations of The American Arbitration Association, Washington, D.C.

F. Notice of Claim. You should not have to make payments to health care professionals or Hospitals except for the required Copayments. If, however You have paid for authorized services which are covered by this Evidence of Coverage You may be reimbursed providing:

Coverage You may be reimbursed providing:

1. You provide NevadaCare with satisfactory evidence that You have properly made such payment to a health care professional or Hospital; and

2. You make the request for reimbursement within six (6) months of the date of service and provide proof of payment. Requests should be submitted to:

NevadaCare
MEMBER SERVICES DEPARTMENT
1701 W. Charleston Blvd., Suite 420
Las Vegas, Nevada 89102

G. Healthy Lifestyle. As a Point of Service member You have access to medical care and coverage of medical care as described in this Evidence of Coverage. Additionally, NevadaCare offers numerous health education and prevention programs which are available to all Members. You are encouraged to maintain a healthy lifestyle, seek medical care when appropriate, and follow the direction and instruction provided by the health care professionals.

H. Maintain Appointments. You have a responsibility to keep the appointment made by or for You with doctors and other providers of care. If You are unable to keep an appointment, always make an effort to notify the provider and cancel at least 24-hours in advance.

I. Authorization to Review Records. By receiving benefits under this Evidence of Coverage, You and Your covered Dependents automatically agree to certain things. You agree that any health professional or Hospital is authorized to furnish to NevadaCare, upon request, all information and records, or copies or [sic] records relating to Your health care services, diagnosis or treatment.

Part XII. General Provisions

A. Entire Contract. This Evidence of Coverage, any attachments, the Group Contract, the Group application and the individual Enrollment Form of the Subscriber constitute the entire Contract between NevadaCare, the Group, the Subscribers and enrolled Dependents; and as of the effective date of this Evidence of Coverage supersede all the agreements between the parties.

B. Form or Content of Contract. No agent or representative of NevadaCare, other than its President, is authorized to change this Evidence of Coverage.

C. Administration of Contract. NevadaCare may adopt reasonable policies, procedures, and rules and interpretations to promote its orderly and efficient administration. These actions will not alter this Evidence of Coverage.

D. Assignment. This Contract is not assignable by the Group or by You without written consent of NevadaCare.

E. Amendment. NevadaCare may amend this Evidence of Coverage in accordance with the provisions contained herein.

F. Litigation for Payment. You may not sue NevadaCare for refusing to pay for services unless You start the suit within one (1) year from the date on which the services were provided or requested.

G. Notice. When a notice is required under this Evidence of Coverage, it must be mailed to:

NevadaCare
1701 W. Charleston Blvd., Suite 420
Las Vegas, Nevada 89102

and to the Group and/or You at the most recent address on file with NevadaCare. You are required to inform NevadaCare of any change of address.

H. Clerical Error. Clerical error, whether of the Group or NevadaCare in keeping any record pertaining to the coverage provided will not invalidate the coverage otherwise validly in force or continue coverage otherwise validly terminated.

I. Information. Information as to how services may be obtained will be furnished to You upon enrollment and may also be obtained upon request from the Member Services Department.

J. Subtitles and Gender. The Subtitles included in this Evidence of Coverage are provided for the purpose of identification and convenience and are not part of the complete Contract. Use of any gender is deemed to include the other gender and, whenever appropriate, the use of the singular is deemed to include the plural (and vice versa).

K. Severability. The provisions of this Evidence of Coverage are severable, and if any provision is held to be invalid, illegal or otherwise unenforceable, in whole or in part, that provision shall not affect in any way the remaining provisions of this Evidence of Coverage.

L. This Evidence of Coverage shall be governed by and construed in accordance with the laws of the State of Nevada and by any applicable Federal statutes.

Supreme Court, U.S.
FILED
MAR 1 2001
OFFICE OF THE CLERK

No. 00-1220

In The

Supreme Court of the United States

NEVADACARE, INC.,

Petitioner,

v.

RUBY SIMKINS and M & K ENTERPRISES,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

RESPONDENTS' BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED FOR REVIEW

Whether the Ninth Circuit correctly found that the district court erred in not interpreting the ERISA Plan's ambiguous terms from the perspective of a lay person of average intelligence and experience; and that a lay person of average intelligence and experience would interpret the ambiguous terms of the ERISA Plan to include coverage for HDC/PSCR.

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RESPONDENTS' BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

Respondents, RUBY SIMKINS ("Ruby") and M & K ENTERPRISES ("M & K") respectfully request that the Court deny the Petition for Writ of Certiorari filed by Petitioner, NEVADACARE, INC. ("NevadaCare") as it fails to present a question worthy of review by the United States Supreme Court.

STATEMENT OF THE CASE

A. Factual Background

Respondent, RUBY SIMKINS ("Ruby") was diagnosed with Stage I breast cancer in October 1996. Ruby's physician removed the growth and advised Ruby to receive treatment and continued monitoring. Subsequently, Ruby's oncologist recommended that she undergo systematic radiation therapy. Ruby began systematic radiation therapy in December 1996 and received a total of thirty-three (33) radiation sessions. Ruby completed her radiation therapy in January 1997. The therapy was successful in resolving the detected nodules in her system.

Following her systematic radiation therapy, Ruby's physicians continued to monitor her recovery and progress by taking blood tests every three (3) months. Ruby's tests continued to show no sign of a relapse. Cautiously, her physicians advised Ruby that she would not be considered "cured" and would continue to be monitored for five (5) years from the date of her radiation therapy.

In the latter months of 1997, Ruby was aware that her employer, M & K ENTERPRISES ("M & K"), was in the process of changing health care providers. Due to her diagnosis and the ever-present possibility of relapse, Ruby was vigilant in making sure that any "new" health care provider would not limit her necessary treatment for breast cancer, should a relapse occur, or limit her need for constant monitoring.

Many persons took steps to insure coverage for Ruby. Ruby periodically called the Personnel Manager for M & K to make sure she would continue to be covered. In turn, the Personnel Manager discussed coverage with the insurance agent who recommended NevadaCare, to confirm that Ruby's and other employees' health problems would be covered. Additionally, before committing to a "new" health care carrier, Louis Simkins, president of M & K, made sure that coverage would continue for Ruby, should she suffer a relapse.

Satisfied that Ruby and other employees would be covered, M & K had an open enrollment on January 1, 1998, for its employees with their new health care carrier, NevadaCare. Ruby enrolled as a participant and/or beneficiary to NevadaCare's plan.

NevadaCare provided each new subscriber and enrolled dependent an Evidence of Coverage ("EOC") booklet describing the covered benefits. App. 52-109. The EOC booklet began with a Table of Contents which the beneficiary could turn to when attempting to determine coverage. App. 53-54. Of importance, the Table of Contents has separate sections indicated for "Services and

Benefits" (Part IV) and "Exclusions, Limitations and Non-Covered Services" (Part VI). *Id.*

In the latter part of January 1998, Ruby felt dizzy and weak and consulted her family physician. Upon submitting for an x-ray and subsequent CAT scan, Ruby was discovered to have at least twelve (12) nodules in her lungs and a plumb size mass on her liver. Ruby was immediately diagnosed with Stage IV breast cancer by her oncologist.

Due to the advanced stage of her cancer, Ruby's treating physicians referred her to the U.C.L.A. Medical Center. At U.C.L.A., Ruby was seen by John Glaspy, M.D., Medical Director of the Bowyer-Surgery Oncology Center. Dr. Glaspy recommended that Ruby undergo state-of-the-art treatment of high dose chemotherapy with peripheral stem cell rescue (HDC/PSCR). Ruby Simkins initiated her treatment by undergoing five (5) chemotherapy sessions in Las Vegas, at the direction of Dr. Glaspy, but under the supervision of her local oncologist.

U.C.L.A. Medical Center requested coverage from petitioner, NevadaCare for the HDC/PSCR procedure via letter dated April 3, 1998. *Respondents' Appendix* 1. In the April 3, 1998 letter, U.C.L.A. specifically outlined that Ruby Simkins needed the high dose chemotherapy procedure, with peripheral stem cell rescue support, and might also need a separate bone marrow support procedure. *Id.* Although the letter requesting approval of the procedure was nothing more than a form letter used by Dr. Glaspy to quickly secure approval for his patients, it is clear that the two procedures, HDC/PSCR and HDC

with bone marrow transplant, were outlined and contemplated to be two distinct and separate procedures. *Id.*

NevadaCare denied coverage, in a letter dated April 30, 1998, simply stating that "[t]he requested services for autologous bone marrow transplant for Ruby Simkins has been reviewed and denied as a noncovered benefit" because "tissue transplant coverage" was limited to allogenic bone marrow transplants. *Res. App.* 2.

Ruby Simkins was forced to frantically secure the funds to undergo the necessary and potentially life-saving peripheral stem cell rescue procedure after NevadaCare unreasonably denied coverage for the same. Ruby was admitted to the U.C.L.A. Medical Center on June 22, 1998 to begin her treatment. On July 3, 1998, Ruby received her peripheral stem cell transfusion. Immediately following her HDC/PSCR procedure, Ruby remained at U.C.L.A. being closely monitored by Dr. Glaspy, and his staff, to ensure positive recovery.

B. High Dose Chemotherapy with Peripheral Stem Cell Rescue

High dose chemotherapy with peripheral stem cell rescue (for the convenience of the Court, hereinafter referred to as "HDC/PSCR") is a widely recognized and state-of-the-art medical procedure used to treat patients with breast cancer. HDC/PSCR is a multi-stage medical procedure designed to treat breast cancer patients with the highest possible success rate.

The first step of the HDC/PSCR procedure involves the patient being injected with a myeloid growth factor

designed to stimulate and multiply the rate of production of stem cells in her blood stream. The physician then extracts the cancer patient's white blood cells from her blood stream, to "harvest" the necessary number of stem cells for transfusion. The harvesting procedure is done by extracting blood from the patient. From this blood, the stem cells are collected. The harvesting is normally a three (3) to four (4) day procedure. Once the requisite number of stem cells have been "harvested" they are frozen and stored until after the high dose chemotherapy is administered.

Next, the patient undergoes a high dose cycle of chemotherapy. There is a direct correlation between the level of chemotherapy and radiation administered to a patient and the amount of cancer destroyed. Thus, high dosages of chemotherapy will be more successful at destroying more cancer cells than lower dosages. These high dosages of chemotherapy, which can be up to several hundred times the normal dosages, not only eradicate cancer cells, but also destroy a considerable portion of the patient's other normal living cells. A patient who is able to withstand higher levels of chemotherapy will have a greater likelihood of effectively controlling or combating her cancer.

Normally, the high level of chemotherapy would prove fatal to the patient. This is because a patient who receives high dose chemotherapy treatment is very susceptible to opportunistic infections due to the eradicating effects of the therapy. In order to "rescue" the patient after the high dose chemotherapy is complete, the patient's own previously harvested and stored stem cells are reinfused into her system. This helps restore immune

functions, thereby minimizing the toxic effects of the high dose chemotherapy and avoiding the otherwise lethal effects of the treatment.

As with any other transfusion procedure, the danger of rejection exists when reinfusing the stem cells back into the body. However, since HDC/PSCR involves the patient's own organic material being reinfused, the danger of rejection is virtually nonexistent.

The final stage often varies in length of time. The patient must be monitored to insure that she does not develop fever or infection. Any such condition or infection could be fatal to the patient. The patient is also monitored to insure that the growth and multiplication of the stem cells is adequate to allow survival of the patient.

For breast cancer patients who are treated with HDC/PSCR, complete responses are achieved in a majority of patients. At a median duration of follow-up examination of two (2) years, approximately 20% remain disease free. Without HDC/PSCR, breast cancer patients like Ruby Simkins, are almost certain to die within weeks.

C. Procedural Background

Respondents filed their complaint on August 7, 1998, with the United States District Court for the District of Nevada. Respondents sought not only to recover costs of the HDC/PSCR procedure, but also injunctive relief preventing petitioner from denying coverage for the procedure.

The district court heard oral arguments on cross motions for summary judgment on June 22, 1999. On July

20, 1999, the district court issued its Order granting summary judgment in favor of petitioner.

Respondents appealed the decision to the United States Court of Appeals for the Ninth Circuit. Oral arguments were heard before the Ninth Circuit panel on June 14, 2000. The Ninth Circuit issued its written opinion on October 3, 2000, and issued an amended opinion on October 31, 2000.

The Ninth Circuit panel reversed the district court's decision, and ordered that summary judgment be entered in favor of Respondents, Ruby Simkins and M & K Enterprises.

MISSTATEMENT OF FACT

Petitioner inaccurately implies that Ruby sought out Dr. John Glaspy at U.C.L.A. for treatment for her breast cancer via a bone marrow supported procedure. *Petition for Certiorari*, 5. More accurately, Dr. Glaspy requested authorization for "high dose chemotherapy with autologous peripheral blood stem cell". *Res. App. 1.* The written request did include the possibility of additional treatment via bone marrow support, should the physicians be unable to collect a sufficient number of stem cells from Ruby's blood. *Id.* Luckily, Ruby's doctors were able to harvest enough stem cells from her blood and the bone marrow support was never needed.

REASONS FOR DENYING THE WRIT

A. Standard considered for granting petition for writ of certiorari not met by petitioner

A Petition for Certiorari is not a matter of right for any party, but rather a matter of judicial discretion. *Rules of the Supreme Court of the Untied States,* Rule 10. Rule 10 outlines the considerations the Court will take into account when considering a petition for writ of certiorari. Specifically, Rule 10 provides,

> "Rule 10. Considerations Governing Review on Certiorari
>
> Review on a writ of certiorari is not a matter of right, but of judicial discretion. ***A petition for a writ of certiorari will be granted only for compelling reasons.*** The following, although neither controlling nor fully measuring the Court's discretion, indicate the character of the reasons the Court considers:
>
> (a) a United States court of appeals has entered a decision in conflict with the decision of another United States court of appeals on the same important matter; has decided an important federal question in a way that conflicts with a decision by a state court of last resort; or has so far departed from the accepted and usual course of judicial proceedings, or sanctioned such a departure by a lower court, as to call for an exercise of this Court's supervisory power;
>
> (b) a state court of last resort has decided an important federal question in a way that conflicts with the decision of another state

> court of last resort or of a United States court of appeals;
>
> (c) a state court or a United States court of appeals has decided an important question of federal law that has not been, but should be, settled by this Court, or has decided an important federal question in a way that conflicts with relevant decisions of this Court." (Emphasis added).

In this case, no compelling reason exists which requires the granting of certiorari. The issuance of an opinion by the Ninth Circuit's panel contrary to petitioner's position, does not constitute a "far reaching" departure or "compelling reason" sufficient enough to warrant granting of the writ for certiorari.

The Ninth Circuit's decision is not one directly "in conflict with the decision of another United States court of appeals on the same ***important*** matter" as outlined in Rule 10(a). Likewise, Ninth Circuit decision in *Simkins* is not "so far departed from the accepted and usual course of judicial proceedings, or sanctioned such a departure by a lower court, as to call for an exercise of this Court's supervisory power".

As outlined below, the instant petition for certiorari does not warrant the Supreme Court's valuable time and judicial resources.

B. Ninth Circuit correctly held that the terms used by petitioner were ambiguous and that a lay person of average intelligence and experience would interpret the terms to provide coverage for the requested HDC/PSCR

ERISA was enacted "to promote the interests of employees and their beneficiaries in employee benefit plans" *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90, 103 S. Ct. 2890, 2896, 77 L. Ed. 2d 490 (1983), and "to protect contractually defined benefits," *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 148, 105 S. Ct. 3085, 3093, 87 L. Ed. 2d 96 (1985), as quoted in *Firestone Tire and Rubber Co. v. Burch*, 489 U.S. 101, 113, 109 S. Ct. 948, 956, 103 L. Ed. 2d 80 (1989). Generally, courts have held that benefit plans are to be read broadly and in a manner that avoids forfeiture of benefits. *Helms v. Monsanto*, 728 F.2d 1416, 1420 (11th Cir. 1984). The Ninth Circuit simply followed the intent of ERISA, and correctly interpreted the plan based on the specific terms used for the vantage point of a lay beneficiary with average intelligence and experience.

1. The Ninth Circuit did not hold that all general medical terms were ambiguous per se

Petitioner attempts to blur the issue by arguing that the *Simkins* decision stands for the overly broad proposition that ***all*** medical terms are ambiguous per se. *Pet.* 10-11. That is not what the Ninth Circuit decision held.

ERISA requires the summary plan description to "be ***written in a manner calculated to be understood by the average plan participant***, and shall be sufficiently accurate and comprehensive to reasonably appraise such

participants and beneficiaries of their rights and obligations under the plan." 29 U.S.C. § 1022(a) (Emphasis added). The Ninth Circuit decision in *Simkins* simply reinforced this requirement.

> The Ninth Circuit's decision outlined that
>
> ***[w]e believe the average person would not understand the term "tissue transplant" to encompass HDC/PSCR, because she would not understand stem cells to be "tissue."*** Instead, the average person would focus on the fact that stem cells in this procedure are a component of the patient's blood . . . ***The average person is not likely to understand blood to be tissue,*** especially when the Plan specifically discusses blood transfusions separately from tissue transplants and places tissue transplant coverage within the organ transplant section, a locational choice that has a distinct potential of misleading and confusing average plan participants. ***Because the stem cells would not be understood to be tissue, the average person would have no reason to believe the tissue transplant exclusion extended to HDC/PSCR.***

App. 12-13. (Emphasis added).

As is easily evidenced by the opinion, by no means did the Ninth Circuit hold that *all* general medical descriptions are ambiguous per se. There is no issue of great uncertainty that needs to be resolved by the Supreme Court as to what medical terms are ambiguous and which are not. Clearly, in accordance with both the *Simkins* decision, and the relevant provisions of the ERISA statute itself (29 U.S.C. § 1022), only vague medical terms that are not clearly understood by a beneficiary of "average intelligence and experience" will be deemed

ambiguous. Those general medical terms used in ERISA plans that are clearly understood by lay beneficiaries will not be deemed ambiguous. This determination should be determined by the individual trial courts, on a case by case basis.

2. The Ninth Circuit's decision does not create a conflict in the operation of the HMO Act and ERISA

Petitioner suggests that the Ninth Circuit's decision in this case, requiring that the plan description to be clear and unambiguous, creates a potential conflict in the operation of two federal statutes, to wit: Health Maintenance Organization Act of 1973 ("HMO Act") and the Employee Retirement Income Security Act of 1974 ("ERISA"). *Pet.* 9-10. Specifically, petitioner argues that the decision "***diminishes*** the ability of HMO plans governed by ERISA to provide low cost medical insurance." *Id.* (Emphasis added). However, petitioner fails to outline specific examples as to how the *Simkins* decision puts ERISA and the HMO Act at odds.

Petitioner's argument is tenuous, hypothetical and unsupported. Courts have considered similar claims by parties that ERISA could hypothetically conflict with the HMO Act, and have failed to give such hypothetical arguments any credence. *See, Hewlett-Packard Company v. Barnes,* 571 F.2d 502, 504-505 (9th Cir. 1978) ("Appellant suggests that some HMOs may ***in the future*** "transform" into employee benefit plans to avoid state regulation, but fails to point out any example of such "transformation," or, for that matter, any specific conflict between ERISA

and the HMO Act. We decline to upset ERISA's preemptive clause on such hypothetical grounds.") (Emphasis added).

Congress' intent to provide lower-cost health care to the public by passing the HMO Act, and ERISA's requirement that a plan description be "written in a manner calculated to be understood by the average participant" are fundamentally not in conflict. Rather, these statutes should be interpreted harmoniously, with each fostering the cost-effective health care for Americans everywhere. Courts must read statutes to give effect to each if this can be done while preserving their respective sense and purpose. *Morton v. Mancari*, 417 U.S. 535, 551, 94 S. Ct. 2474, 2483, 41 L. Ed. 2d 290 (1974).

The only thing the *Simkins* decision requires, is that the plan be drafted clearly, from the perspective of a lay person of average intelligence and experience so that the same lay person would be able to discern what procedures were covered and what procedures were excluded from coverage. This is identically what is required from the statute itself. The *Simkins* decision creates no more tension between the statutes. Accordingly, petitioner's argument deserves to be given no weight.

3. Simple definitions could have clearly put Ruby on notice that the HDC/PSCR procedure would not be covered, without much cost to petitioner

Petitioner argues that the Ninth Circuit decision in this case would require them to draft plans "choked with detail and hopelessly confusing" descriptions of over

94,000 procedures. *Pet.* 14-15. This argument is a gross exaggeration of the requirements required by statute.

As outlined above, ERISA requires plans to be drafted ***"in a manner calculated to be understood by the average plan participant . . . "*** 29 U.S.C. § 1022(a). Assuming this policy was intended generally to provide coverage for medical care and not exclude coverage for 94,000 procedures, the focus is on the clarity of which procedures they intend to communicate to the insureds were excluded. In this case, petitioner could have done an array of things to comply with these requirements.

For instance, petitioner could have included select definitions which would assist in clearly describing coverage to their beneficiaries without the fear of "choking" their policies with a list of 94,000 specific procedures. Logic dictates, and courts have followed, that when determining coverage under ERISA plans, one of the starting points is to review the definition section of the plan. *See, Schachner v. Blue Cross and Blue Shield of Ohio*, 77 F.3d 889 (6th Cir. 1996) (in determining coverage for employee's cardiac rehabilitation therapy, the court turned to the definition for "Treatment by Physical Means" to determine the existence of any ambiguity. The Sixth Circuit determined the phrase unambiguous relying on the definition included in the certificate.). The Ninth Circuit similarly took into consideration the definition section of the plan at issue in reaching its decision.

The Ninth Circuit reconciled the lay beneficiaries interpretation of "covered benefits" by considering, *inter alia*, the list of definitions outlined in the plan.

Petitioner could have accomplished the clarity required by the Ninth Circuit's decision by simply including a descriptive definition for "blood transfusion." Such a definition could concisely outline that transfusions which are performed to accomplish the re-infusion of "tissue," such as stem cells, would not be covered as a blood transfusion. Or petitioner could have included a definition/provision that transfusions, coupled with other procedures, such as high dose chemotherapy, would likewise not be covered under the plan. These or other simple definitions were never included in the plan. App. at 54-66.

In fact, petitioner's plan not only does not define "blood transfusion", but also does not define "blood." *Id.* A simple definition for blood could have outlined those components, like stem cells, whose re-infusion would not be covered under the covered benefit "blood . . . and [its] administration." App. 75. Further, the definition for blood could have specified that "blood components," such as stem cells, would be considered "tissue" for purposes of determining coverage. The plan contained no such definition/provision.

As the Ninth Circuit also pointed out, "[a]n average person would also reasonably conclude that the general term chemotherapy covers all levels of chemotherapy used in treatment."[1] The plan also did not include a

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[1] Petitioner finds fault with the Ninth Circuit's analysis in looking at the separate provision providing coverage for "chemotherapy" when determining the reasonable interpretation by a lay beneficiary. *Pet.* 17 note 5. Petitioner contends that the Ninth Circuit's determination that the

definition for "chemotherapy" or "high dose chemotherapy," or any provision outlining which "chemotherapy" procedures would be covered and which would not. App. 54-66.

As the Ninth Circuit outlined, courts have long held that "insurers should be expected to set forth any limitations on its liability clearly enough for a common lay person to understand; if it fails to do this, it should not be allowed to take advantage of the very ambiguities that it could have prevented with greater diligence." *Kunin v. Benefit Trust Life Insurance Co.*, 910 F.2d 534, 540 (9th Cir. 1990). Courts have held that ERISA's summary plan description requirements were intended to arm employees with enough information to enable them to enforce their rights under the plan. *See, Sanatana v. Deluxe Corp.*, 12 F. Supp. 2d 162 (D. Mass 1998). In this case, petitioner chose not to include any such simple definitions as part of its plan, preferring to vaguely address broad areas of coverage and exclusions. This Court should not reward petitioner for its poorly drafted, misleading and vague policy by granting certiorari.

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provision providing coverage for "chemotherapy" could be interpreted to include coverage for all chemotherapy is somehow flawed. Petitioner argues that "[i]t is medically unadvisable, if not impossible, to receive HDC as a stand-alone procedure." *Id.* Petitioner's criticism then begs the question: if it is medically unadvisable, if not impossible, to receive HDC as a stand-alone procedure, why does the plan, drafted by petitioner, provide coverage for "chemotherapy" without reference to any other supportive procedure? App. at 75. Petitioner is responsible for the reasonable interpretation it now chastises the Ninth Circuit for making. It should not be allowed to benefit from its own ambiguities.

4. Ninth Circuit did not sanction the billing practice of "unbundling" in determining coverage in ERISA plans

Petitioner argues that the Ninth Circuit decision sanctions providers and insureds to engage in the billing practice of "unbundling" when dealing with ERISA plans. *Pet.* 16-17. Petitioner wants the Supreme Court to believe that the Ninth Circuit condones the billing practice, and relied solely on "unbundling" in reaching its decision. *Pet.* 16-19. Again, this is simply inaccurate.

As petitioner points out, "unbundling" is a billing practice that occurs when a provider bills for both a "major" and "minor" procedure on the same day of service in an effort to receive payment for components which might not be covered collectively, or to receive higher payments by billing them separately. *Pet.* 17. The Ninth Circuit did not address the billing practice of "unbundling," instead focusing on a reasonable beneficiary's consideration in "trying to assess whether an insurance plan covered a complex procedure." App. 29, note 6. The Ninth Circuit determined that such considerations would reasonably include whether the plan covered the component subparts of the complex procedure.

The Ninth Circuit recognized *Hendricks v. Central Reserve Life Insurance Co.*, 39 F.3d 507 (4th Cir. 1994), which denied consideration of the fragmenting of the procedure when denial of coverage was based on the "experimental" exclusion. However, as the Ninth Circuit correctly held, *Hendricks* is distinguishable from the instant case, where the procedure was denied not under

an "experimental" exclusion, but under a "tissue transplant" exclusion. App. 14. The Ninth Circuit distinguished the cases, by correctly determining that in cases where the Court is asked to determine the ambiguity of terms used in a plan, "[a]n average person trying to assess whether an insurance plan covered a complex procedure reasonably would look to whether the component parts are covered . . . " *Id.*

C. The Ninth Circuit did not rely on *contra proferentem* in reaching its decision that the district court erred in granting summary judgment for petitioner

Petitioner raises the specter of the *contra proferentem* rule by citing an array of cases to illustrate that different courts have applied the doctrine of *contra proferentem* in the ERISA context, while others have not. *Pet.* 19-23. Petitioner hopes that this canvassing exercise is sufficient to warrant granting of its petition for writ of certiorari in the instant case.[2] It is not.

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[2] It should also be pointed out that in the cases cited by petitioner, where the *contra proferentem* rule was accepted or rejected in the ERISA benefits context, the parties have either deemed it unworthy to petition the Supreme Court for writ of certiorari to review the split in Circuits or the Supreme Court has itself refused to grant certiorari to review the same. *Pet.* 22-23. Similarly, the Supreme Court should refuse to grant certiorari in this case. The application of a doctrine construing ambiguous policy language against the insurer is not an important matter for the highest court in the country to review. This is particularly true, when the Circuit Court applied a different statutory rule of construction in rendering its ruling, to wit: 29 U.S.C. § 1022(a).

Although petitioner goes to great lengths to outline the split among circuits concerning the use of *contra proferentem* rule, it fails to point out to this Court that the Ninth Circuit never relied on the rule in reaching its decision that the district court erred in granting summary judgment in favor of petitioner. App. 1-16. In actuality, the Ninth Circuit reached its decision by summarizing that ***"[b]ecause the Plan can reasonably be read to cover HDC/PSCR***, the district court improperly granted summary judgment to NevadaCare."[3] App. 15 (Emphasis added).

The Ninth Circuit relied exclusively in its decision by applying the standard already required by ERISA. That is, that the summary plan description "shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan." 29 U.S.C. § 1022. As its starting point, the Ninth Circuit analyzed the actual language and terms used by petitioner in its plan, and "considered whether a person of average intelligence and experience would construe the term 'tissue transplant' to encompass HDC/PSCR." App. 12. The Ninth Circuit determined such an average person would not understand the ambiguous term to

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[3] The Ninth Circuit did go on to apply the *contra proferentem* rule in entering summary judgment in favor of Simkins by holding that "the existence of such a reasonable interpretation means that, even if contrary reasonable interpretations exist, a jury would be required to adopt the one that favors coverage for the insured . . . the district court should have granted Simkins' motion for partial summary judgment." App. 15.

exclude HDC/PSCR because such a person "would not understand stem cells to be 'tissue.' " App. 12-13.

In fact, the petitioner itself never argued that the split in circuits regarding *contra proferentem* was an issue that the Ninth Circuit needed to address. Res. App. 5-27. Only now does the petitioner raise the split between the circuits in a desperate attempt to secure review by this Court. As outlined above, the *contra proferentem* rule was not applied by the Ninth Circuit in reaching its decision regarding the wisdom of the district court's granting of petitioner's motion for summary judgment. However, it appears that petitioner would essentially request the Supreme Court to apply a reverse *contra proferentem* rule that would construe poorly drafted, unclear language against the insured. Therefore, Court should not grant the petition for writ of certiorari simply to resolve an academic exercise desperately presented by petitioner at the eleventh hour.

D. Petitions for writ of certiorari have been consistently denied in similar ERISA cases

The United States Supreme Court has repeatedly denied certiorari in similar cases where the Ninth Circuit Courts of Appeals has determined the ambiguity/non-ambiguity of specific policy provisions within an ERISA plan. *See, Kunin v. Benefit Trust Life Insurance Co.*, 910 F.2d 534 (9th Cir. 1990) (ERISA plan's term "mental illness" in policy limitation held ambiguous), *cert. denied*, 498 U.S. 1013 (1990), *rehearing denied*, 498 U.S. 1074 (1991); *Peterson v. American Life & Health Insurance Co.*, 48 F.3d 404 (9th Cir. 1995) (ERISA policy exclusion for coronary bypass

surgery held unambiguous), *cert. denied*, 516 U.S. 942 (1995); *Aul v. Allstate Life Insurance Co.*, 953 F.2d 1386 (9th Cir. 1992) (ERISA policy unambiguously precludes vesting of benefits), *cert. denied*, 506 U.S. 1021 (1992); *Marsh By and Through Marsh v. Allstate Life Insurance Co. of New York*, 953 F.2d 1387 (9th Cir. 1993) (ERISA termination provision does not conflict with other provisions and is therefore not ambiguous), *cert. denied*, 510 U.S. 826 (1993).

The denial of certiorari is not limited to those cases involving the Ninth Circuit. The United States Supreme Court has also consistently denied certiorari to cases determining the ambiguity/non-ambiguity of specific policy provisions within an ERISA policy from other courts. *See, Brewer v. Lincoln National Life Insurance Co.*, 921 F.2d 150 (8th Cir. 1990), *cert. denied*, 501 U.S. 1238 (1991); *Schachner v. Blue Cross and Blue Shield of Ohio*, 77 F.3d 889 (6th Cir. 1996), *cert. denied*, 519 U.S. 865 (1996).

CONCLUSION

Petitioner argues that the instant case involves "[i]mportant and substantial questions" arising from the Ninth Circuit opinion. In reality, although breast cancer treatment and insurance coverage for breast cancer treatment is of vital concern in our country, this case involves a very narrow decision by the Ninth Circuit as to the specific language included in NevadaCare's unique policy provision, and the applicability of that language to the requested HDC/PSCR procedure requested by Ruby Simkins. There is no demonstration that the resolution of the language at issue has some far reaching effect beyond

this case. The Ninth Circuit opinion is written narrowly so as to apply almost exclusively to the instant action. There will be no far reaching effect resulting from the panel's decision which might warrant the granting of certiorari.

The petition for writ of certiorari should be denied in all respects.

Respectfully submitted this 1st day of March, 2001.

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Counsel for Respondents
Ruby Simkins and
M & K Enterprises

USLA Medical Center

[Address Omitted In Printing]

April 03, 1998

Nevadacare
Att: Case Management

Re: Ruby Simpkins*

Crt: 152320950 01

Group: 130047

Sub: Louis Simpkins

Pending #'s: Dr. Glaspy P71460 / Facility P71461

To Whom It May Concern,

Ms. Simpkins is a 54 year old female referred to UCLA Medical Center for high dose chemotherapy with autogolous peripheral blood stem cell +/- bone marrow support. Ms. Simpkins has a diagnosis of Breast Cancer.

I am requesting *written medical necessity authorization* for the above procedure. We cannot begin treatment without prior authorization. The procedure will include Catheter Placement, Pheresis (both conducted as outpatient procedures) and then Admit for High Dose Chemotherapy and Stem Cell Transplant.

Your attention to this matter is appreciated. If you have any medical questions, please contact Sara Rasti, R.N., at (310) 206-3806.

Please reply with a decision regarding this case as soon as possible by FAX (310) 206-5469 or phone (310) 206-7920.

---

* Correct spelling should be Simkins.

Sincerely,

/s/ Ellen M. Steingrebe
Ellen M. Steingrebe
Bone Marrow Transplant Insurance Coordinator
UCLA School of Medicine
10945 Le Conte Ave., Suite 2120
Box 957049
Los Angeles, CA 90095-7049

Res. App. 3

NevadaCare

M & K Enterprises
Louis Simkins
3748 Scripps Way
Las Vegas, NV 89103

April 30, 1998

Plan: NevadaCare POS 3E-97

Employer Group: 130047

Dear Mr. Simkins,

This letter is to inform you of the following: The requested services for a autologous bone marrow transplant for Ruby Simkins has been reviewed and denied as a noncovered benefit. The NevadaCare evidence of coverage (EOC), which you received at the time of enrollment outlines the benefits of transplant services and specifically states that tissue transplant coverage is limited to allogenic bone morrow only. This denial of benefits is a denial of plan coverage and is not related to the medical necessity, per the diagnosis.

If you have any questions or need additional information, please do not hesitate to contact NevadaCare at (702) 474-7241.

Sincerely,

/s/ Baltazar A. Lozano, Jr
Baltazar A. Lozano, Jr.
Director of Claims and Client Services

CC: Keith Beagle, President
Eddie Burkhart, Director of Sales and Marketing
John Thielen, Sales Representative
Carl Ross, RN, UR/QA Manager
Jean Patrick, RN, Utilization Review
Claims/Client Services Staff

No. 99-16844

IN THE
UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

RUBY SIMKINS and
M & K ENTERPRISES,

Plaintiffs-Appellants,

v.

NEVADACARE, INC., a Nevada corporation,
JOHN DOES I through X and
DOE CORPORATIONS I through X,

Defendants-Appellees.

APPEAL FROM THE UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

BRIEF FOR THE APPELLEE NEVADACARE, INC.

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* * *

STATEMENT OF SUBJECT MATTER AND APPELLATE JURISDICTION

The Appellee, NevadaCare, Inc., has no objection to the statement of subject matter and appellate jurisdiction as set forth in the appellant's Brief.

ISSUES PRESENTED FOR REVIEW

1. Whether the District Court erred in granting NevadaCare, Inc.'s Counter-Motion for

Summary Judgment, holding that the plain unambiguous language of the pertinent provision of the Plan, Paragraph R, which provides that "[t]issue transplant coverage is limited to allogenic bone marrow only," did not require coverage of the HDC/PSCR procedure, which undisputedly is a tissue transplant, but not an allogenic bone marrow transplant.

2. Whether the District Court erred in denying Simkins' Motion for Summary Judgment requesting coverage for a procedure which is beyond the scope of benefits Simkins is entitled to receive under the Plan.

STANDARD OF REVIEW

The standard of review on appeal of a District Court's grant of summary judgment is "de novo." *Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317 (9th Cir. 1995), *citing Jesinger v. Nevada Fed. Credit Union*, 24 F.3d 1127, 1130 (9th Cir. 1994). In reviewing the District Court's decision, this Court must "engage in the same exercise as the district court." *Donato v. Metropolitan Life Ins. Co.*, 19 F.3d 375, 380 (7th Cir. 1994). Where, as in the instant case, the parties do not contest the facts, the Appellate Court needs only to decide whether the District Court correctly applied the substantive law. *Associated Gen. Contractors v. Smith*, 74 F.3d 926, 929 (9th Cir. 1996).

In cases pertaining to claims based on the Employment Retirement Income Security Act 29 U.S.C. § 1001, *et. seq.* ("ERISA"), where the plan document endowed the fund with authority to interpret the terms of the plan, the Appellate Court "would be required to accept the fund's

reading of the plan document so long as it was not 'downright unreasonable.' " *Id. See also Killian v. Healthsource Provident Adm'rs, Inc.*, 152 F.3d 514, 520 (6th Cir. 1998), *Miller v. Metropolitan Life Ins. Co.*, 925 F.2d 979, 986 (6th Cir. 1991).

BRIEF STATEMENT OF THE CASE

This case arises out of the denial of ERISA plan benefits for the procedure known as high dose chemotherapy with peripheral stem cell rescue ("HDC/PSCR"). Appellant Louis Simkins, dba M&K Enterprises ("M&K") had contracted with NevadaCare, Inc. ("NevadaCare") for benefits as set forth in the NevadaCare Point of Service Evidence of Coverage ("EOC" or the "Plan"). *See* CR 13 at Exh. 8. Appellant Ruby Simkins ("Simkins") was a beneficiary under the Plan. Simkins and M&K originated the instant action challenging on numerous grounds the decision of NevadaCare to deny benefits for the HDC/PSCR based on the determination that the requested treatment was not an item covered under the plan. The District Court granted the Counter-Motion for Summary Judgment filed by NevadaCare, affirming the denial of coverage. Simkins appealed the holding of the District Court.

SUMMARY OF ARGUMENT

The District Court properly held, based on the pleadings and record before it, that NevadaCare's denial of benefits for Simkins' HDC/PSCR was proper under the clear terms of the Plan. The Plan provides that only certain services are covered, and HDC/PSCR is not listed

as a covered service. Simkins' original request for coverage was for a bone marrow tissue transplant. While there is coverage for tissue transplants under the plan, such coverage is expressly limited to "allogenic bone marrow transplants." *See* CR 13, Exh. 8 at p. 000026. As HDC/PSCR does not involve an allogenic bone marrow transplant, it is not covered under the tissue transplant provision. The Plan provisions in this regard are conspicuous and unambiguous, as the terms of the Plan are not susceptible to more than one reasonable interpretation, especially taken in the context of the entire document.

The District Court further properly held that because the Plan grants NevadaCare discretionary authority in coverage decisions, NevadaCare's denial of benefits to Simkins must be reviewed for "abuse of discretion." NevadaCare's refusal of payment for an uncovered bone marrow transplant was based on a reasonable reading of the Plan terms, and does not constitute abuse of discretion.

The argument that alternative grounds for coverage of HDC/PSCR could be found by fragmenting it into a blood transfusion and chemotherapy is not properly before this Court, as it is raised for the first time on appeal. Assuming *arguendo* that the blood transfusion argument may be considered, it nevertheless must fail as the law does not allow the insured to fragment the procedures in this way to obtain coverage. Furthermore, it is an undisputed medical fact that HDC/PSCR involves not a blood transfusion, but a tissue transplant, and any contrary view is erroneous and unreasonable.

For the above reasons, the District Court's holdings in this matter are correct, and must be affirmed.

ARGUMENT

A. The District Court did not err in its conclusion that "the plain unambiguous language of NevadaCare's EOC requires denial of coverage for Ms. Simkins HDC/PSCR."

The District Court correctly determined that no ambiguity exists in the Plan in connection with the denial of coverage for Simkins' HDC/PSCR. Plans governed by ERISA are interpreted in accordance with the federal law. *See Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 110, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989). A contract must be read as a whole, and every part interpreted in the context of the whole, with preference given to reasonable interpretations. Contract terms should be given their ordinary meanings, and when the terms of a contract are clear, the intent of the parties must be ascertained from the contract itself. *Klamath Water Users Protective Ass'n v. Patterson*, 191 F.3d 1115, 1119 (9th Cir. 1999). Straightforward language in an ERISA policy, as in any other contract, must be given its plain natural meaning. *Fischman v. Blue Cross & Blue Shield of Conn., Inc.*, 775 F. Supp. 513, 515 (D. Conn. 1991).

Ambiguity only exists in a contract when a term is one that is "susceptible of two or more distinct meanings . . . **Terms that are merely vague or indefinite are not construed against the drafter under the doctrine of *contra preferentem*.**" *Atwood*, 45 F.3d at 1324 (9th Cir.

1995) (Emphasis added). A court may not find an ambiguity based on "a strained instead of reasonable interpretation of . . . terms." *Tzung v. State Farm Fire and Casualty Co.*, 873 F.2d 1338, 1340 (9th Cir. 1989). An ambiguity may not be created "where the contract has a definite meaning, and where no reasonable basis exists for a difference of opinion about that meaning." *Brass v. Am. Film Techs., Inc.*, 987 F.2d 142, 149 (2d Cir. 1993).

Part IV of the Plan sets forth all of the "Services And Benefits Within the Managed Care Network." The first paragraph of this section provides:

> "You are eligible to receive the following medical car and services of doctors and other providers including medical, surgical, diagnostic, therapeutic and preventive services which are generally and customarily provided within the Managed Care Network."

See CR 13, Exh. 8 at 000021. An extensive list of covered services then follows. The only reasonable interpretation of this provision is that a Member is eligible for benefits under the Plan only in connection with the services listed in that Part. Such interpretation is also confirmed by reading the Plan as a whole, with a specific reference to the Part VI, § 29, which contains an exclusion for "[a]ny services or supplies not specifically listed in this Evidence of Coverage as covered benefits, services or supplies." See CR 13, Exh. 8 at 000030. HDC/PSCR is not listed in the Plan as a covered item.

Coverage for tissue transplants under the Plan, however, is limited under the following provision, adjudged unambiguous by the District Court:

R. Transplant Services

Coverage is provided for the Medically Necessary services required for **human tissue** and organ **transplants**, for the treatment of non-occupational disease or injury. All transplant related services must be pre-authorized by the NevadaCare Medical Director.

1. Organ transplants for heart, kidney, cornea, and liver. Liver transplant limited to that required as a result of biliary artresia only.

2. Tissue transplant coverage is limited to allogenic bone marrow only.

3. Coverage is provided for the necessary Hospital, surgical, laboratory, and x-ray expenses incurred by a donor for an authorized transplant to a Member, unless the donor has coverage for such expenses. (Emphasis added).

See CR 13, Exh. 8 at 000026. The exclusionary provision in the Plan further limits the tissue transplant coverage granted under the benefit provision. See CR 13, Exh. 8 at 000030. This provision is as follows:

31. We will cover services for covered organ transplant expenses, as defined below, incurred by a Member for an organ transplant approved by Us at a facility approved by Us, subject to those conditions and limitations described below. Transplant means pre-transplant, transplant and post-discharge services, and treatment of complications after transplantation. We will cover only services, care and treatment received for or in connection with the approved transplantation of the following human organs:

1. Heart, Kidney, Cornea, and Liver. Liver transplant is limited to that required as a result of biliary atresia only.

2. Tissue transplant coverage is limited to allogenic bone marrow only.

For a transplant procedure to be considered approved, prior approval from the company's Medical Director is required in advance of the procedure.

Covered Expenses: For approved transplant procedures, and all related complications, We will cover only the following covered expenses:

1. Hospital expenses and physician's expenses will be covered under the same terms and conditions as We will cover care and treatment of any other covered injury or sickness, up to a maximum of $150,000 per transplant procedure.

2. Organ acquisition and donor cost. However, donor costs are not covered under the Group Plan if they are payable in whole or in part by any other Group Plan, insurance company, organization or person other than donor's family or estate. In addition, We will not cover acquisition and donor costs related to the removal of an organ from a Member for the purpose of transplantation into a recipient who is not our Member. (Emphasis added.)

There is also a catchall exclusion in the policy for "Any services or supplies not specifically listed in this Evidence of Coverage as covered benefits, services or supplies." See CR 13, Exh. 8, at 000030.

It is undisputed that HDC/PSCR is a tissue transplant. The only kind of tissue transplant covered under

the Plan is an allogenic bone marrow transplant. This policy provision is contained in both the benefit and exclusion provisions of the policy. It is undisputed that the HDC/PSCR procedure does not involve an *allogenic* bone marrow transplant. Rather, it involves an "autologous peripheral blood stem cell transplantation." Therefore, a reasonable beneficiary would not expect the above reference Plan provision to cover HDC/PSCR.[1] No ambiguity exists in this regard, as the provision of the Plan are not susceptible of two ore more distinct meanings and no other reasonable interpretation is possible. *Atwood*, 45 F.3d at 1324, *Klamath*, 191 F.3d at 1119, *Tzung*, 873 F.2d at 1340.

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[1] As Simkins' oncologist Dr. Glaspy noted in his Affidavit, *see* CR 9, a hypothetical average beneficiary could not be expected to know about the HDC/PSCR procedure, or what is involved in such a procedure, until it has been proposed or explained to such a person by a doctor in a manner similar to the explanation received by Simkins. It would be reasonable to expect a beneficiary to understand, after such an explanation, that HDC/PSCR does not involved an **allogenic** bone marrow transplant, but, to the contrary, involves re-transplantation of cells obtained from the patient's own body. Furthermore, following an explanation by a physician, it is reasonable to expect a patient to understand that "blood filtering to harvest stem cells," is not a mere blood transfusion, is involved in HDC/PSCR. See CR 9 at 000026.

B. Simkins' new contention that HDC/PSCR was covered under the blood transfusion and chemotherapy provisions of the Plan is waived because is it raised for the first time on appeal.

For the first time in the appellate brief, Simkins argues that HDC/PSCR should be covered because the NevadaCare Plan provides coverage for Chemotherapy and blood transfusions. While it is less than clear, Simkins appears to be arguing that coverage should be afforded under this theory because a reasonable person would believe that HDC/PSCR was covered under the chemotherapy and blood transfusion sections. This contention does not appear in the record. Further, Simkins herself did not appear to have had this "reasonable" belief at the time she prepared her Affidavit to Plaintiff's Motion for Summary Judgment and for a Permanent Injunction (See CR9, Affidavit of Ruby Simkins), which makes no mention of this latest interpretation of the Plan. Inexplicably, Simkins now also appears to argue that the procedure she underwent actually included a blood transfusion. Again, there is no evidence whatsoever supporting this statement.

To the contrary, the record below indicates that when Simkins' physicians requested coverage for the HDC/PSCR procedure, which she actually underwent, they referred to the procedure as a HDC/PSCR or high dose chemotherapy with autologous bone marrow transplant ("HDC/PSCR").[2] None of Simkins doctors ever

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[2] In an April 3, 1998 letter to NevadaCare, (*see* CR 9, Exh.1) Ms. Ellen M. Steingrebe, Bone Marrow Transplant Insurance Coordinator on behalf of the UCLA Medical Center, requested

suggested that the procedure they were recommending was a "simple blood transfusion" as Simkins now contends.

In her Motion for Permanent Injunction and Motion for Partial Summary Judgment, Simkins vigorously argued that HDC/PSCR is separate and distinct from an autologous bone marrow transplant and argued that *"Ruby Simkins is not requesting a bone marrow transplant."* (Emphasis added). See Motion for Permanent Injunction, CR 9, page 16. The District Court in this regard held that "[r]egardless of whether these are two different procedures, the **undisputed evidence** show they are both tissue transplants. Paragraph R states that the only tissue transplant that is covered under Ms. Simkins' plan is an allogenic tissue transplant." See Order, CR24, Page 13, (Emphasis added).

The District Court, based on the record before it, properly held that Simkins is not eligible for the requested benefits under the express terms of the Plan. The "blood transfusion" argument is improperly before this Court as well as flagrantly inconsistent with the record and legal precedent.

The "blood transfusion" argument has not been raised by Simkins in any pleading before the District

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"written medical necessity authorization" for " . . . high dose chemotherapy with autologous peripheral blood stem cell +/- bone marrow support . . . " Likewise, in the May 11, 1998 letter to Baltazar A. Lozano of NevadaCare, (*see* CR 13, Exh. 27) Dr. John Glaspy wrote: "As I am sure you are aware **autologous peripheral blood stem cell transplantation** is not an experimental technique, but rather a supportive technique . . . "

Court and is, therefore, waived on appeal.[3] Generally, Appellate Courts will not consider contentions raised for the first time on appeal. *Smith v. Marsh*, 194 F.3d 1045, 1052 (9th Cir. 1999). "Before an argument will be considered on appeal, 'the argument must be raised sufficiently for the trial court to rule on it.' " *Sofamor Danek Group, Inc. v. Brown*, 124 F.3d 1179, 1186 n.4 (9th Cir. 1997).

While there are exceptions to the rule that new issues may not be raised for the first time on appeal, none of the exceptions are applicable in this instance. *See Peterson v. Highland Music, Inc.*, 140 F.3d 1313, 1321 (9th Cir. 1998). The interests of justice dictate the exclusion of Simkins' new argument raised against NevadaCare at this late stage of the proceedings. There is no new legal issue or change in the law, justifying consideration of this new argument. Simkins failed to argue that any of the exceptions to the general rule apply, or mention any "exceptional circumstances" which prevented the issue from being raised in the District Court. **Thus, Simkins is now precluded from raising this issue.**

Furthermore, this Court should refuse to consider the contention that the HDC/PSCR is covered under the blood transfusion provision because Simkins has never made such an argument to the plan administrator. In *Taft v. Equitable Life Assurance Soc'y*, 9 F.3d 1469, 1472 (9th Cir. 1993), the court emphasized:

> **Nothing in the legislative history suggests that Congress intended that federal district courts**

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[3] *See also* Ninth Cir. Ct. Rule 28-2.5 ("As to each issue, appellant shall state where in the record on appeal the issue was raised and ruled on . . . ")

> **would function as substitute plan administrators**, a role they would inevitably assume if they received and considered evidence not presented to administrators concerning an employee's entitlement to benefits. Such a procedure would frustrate the goal of prompt resolution of claims by the fiduciary under the ERISA scheme. (Emphasis added).

For the reasons stated above, Simkins' contention that HDC/PSCR is covered under the blood transfusion provisions **should be disregarded by this Court**. *Id., see also Federal Deposit Insurance Corporation v. Castetter*, 184 F.3d 1040, 1046 n.5 (9th Cir. 1999), *Peterson*, 140 F.3d at 1321 (9th Cir. 1998).

C. Assuming arguendo that she had properly raised the blood transfusion issue below. Simkins should not be allowed to fragment the HDC/PSCR procedure into components in an attempt to obtain coverage.

Even if Simkins had properly asserted her blood transfusion argument before the District Court, Simkins this argument must fail as an impermissible fragmentation of the procedure to obtain coverage, impermissible under the law. In *Mattive v. Healthsource of Savannah, Inc.*, 893 F. Supp. 1559 (S.D. Ga. 1995), cited in the Simkins' appellate brief, the court held with respect to the coverage of HDC/PSCR procedure:

> **[t]he Court agrees with Defendant's argument that the Court should view the treatment as a whole and not fragment for the purposes of coverage. In this case, the Court agrees with**

> **the Fourth Circuit which has held that the fragmenting of the phases of treatment and the consideration of whether each fragment was covered under the terms of the contract produces "an unrealistic and distorted analysis."** *Hendricks v. Central Reserve Life Insurance Co.*, 39 F.3d 507, 514 (4th Cir. 1994). The court held that fragmenting in this was would (sic) allow partial coverage for almost any treatment "no matter how inconsistent with good medical practice." *Id.* at 515 (Emphasis added).

See also Hasty v. Central States, 859 F. Supp. 339 (N.D. Ind. 1994). The position taken by Simkins in her Appellate Brief is similarly unrealistic and distorted. In the District Court, all the parties, including Simkins and her counsel, treated HDC/PSCR as an integrated treatment, not susceptible to fragmentation into parts and not involving a blood transfusion.

Simkins' treating oncologist, Dr. Glaspy, stated in his Affidavit that "HDC/PSCR is a multi-step procedure," involving chemotherapy and cell harvesting. *See* CR9 at 000024. In his description of the procedure, (*see* CR9 at 000024-26) Dr. Glaspy never mentioned that a blood transfusion was in any way connected with the proposed treatment. Simkins never applied for coverage for a "blood transfusion" and did not undergo such a treatment. She received a stem cell transplant, described as such by her doctors, her counsel, and the courts. *See e.g. Wheeler v. Dynamic Eng'g, Inc.*, 62 F.3d 634 (4th Cir. 1995), extensively relied upon by Simkins:

> Stem cells are also located in the circulating, or peripheral, blood. In HDC/PSCR, the procedure

> at issue in this litigation, stem cells are harvested from a patient's bloodstream rather than from bone marrow. Prior to the administration of the HDC, blood is withdrawn from the patient and stem cells are separated from the blood by a process known as leukapheresis. Stem cells are then frozen and stored until after the administration of the HDC. After the HDC phase, **the stem cells are thawed and reinfused into the patient's bloodstream**. (Emphasis added).

The blood transfusion argument raised by Simkins has been unsuccessfully attempted in the case of *Bruening v. Constr. Workers Health Fund*, 165 F.3d 31, 1998 WL 691027 (7th Cir. (Wis.) 1998) (*Unpublished*).[4] The court, referring to the opinion of an independent medical review firm, Medical Review Institute of America, Inc. ("MRI"), stated:

> . . . although the stem cells are drawn from the blood in a PSCR, they are: (1) simply tissue suspended in the blood, rather than a functioning part of the blood; (2) returned to the patient by the same means as in an ABMT (catheterization followed by re-implantation in the marrow); and (3) "transplanted" in the same sense that marrow is in an ABMT. In this report, MRI explicitly concluded that the PSCR was a "tissue" transplant.

An interpretation of the HDC/PSCR provision as involving a blood transfusion is, therefore, erroneous, inconsistent with the undisputed medical facts, and

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[4] The unpublished decision is referred to herein for illustrative purposes only.

unreasonable. As such, it cannot give rise to coverage under the Plan.

D. The District Court correctly determined that NevadaCare's decision to deny coverage for Simkins' HDC/PSCR should be reviewed under the "abuse of discretion," not "de novo" standard[5]

The law in the Ninth Circuit pertaining to the standard of review of an ERISA administrator's decision is well-established. A denial of benefits challenged under 29 U.S.C. § 1132(a)(1)(B) is reviewed de novo 'unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan,' in which case an "abuse of discretion"[6] standard is applied. *Atwood*, 45 F.3d at 1321 (9th Cir. 1995), citing *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115, 109 S.Ct. 948, 956-57, 103 L.Ed.2d 80 (1989).

The District Court determined that the following provisions of the subject Plan give NevadaCare discretionary authority:

> Medically Necessary – The use of services and/or supplies, as described in this Evidence of

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[5] The District Court emphasized that its holding in the instance case would not change if the applicable standard of review had been "de novo."

[6] Some of the Ninth Circuit cases state that an "arbitrary and capricious" standard is applied, while others use the term "abuse of discretion." The standards differ in name only. *Atwood*, 45 F.3d at 1321 N.1.

Coverage, which are required to identify or treat Your illness or injury and which are:

a. consistent with the symptoms or diagnosis and treatment of Your condition, disease, ailment or injury;

b. appropriate, safe, and effective with regard to standards of good medical practice;

c. not solely for Your convenience, Your Physician, Hospital or other health care provider;

d. consistent with the most appropriate supply of level of service which can be safely provided to You. When applied to an inpatient, it further means that Your medical symptoms or condition require that the diagnosis or treatment cannot be safely provided to You as an outpatient; and

e. consistent with medical policy and procedure as defined by the NevadaCare Quality Management Program. (*See* CR 13, Exh. 8 at 000015-16)

Prior/Pre-Authorization. That a Participating Provider or Physician must receive approval from an authorized staff member of NevadaCare, such as the Medical Director or his designee, before You can receive certain health care services. (*See* CR 13, Exh. 8 at 000016)

Complaint and Grievance Procedure.

. . .

NevadaCare will make a final decision for grievance about medical care services within fifteen (15) days of receiving written or oral

> **grievance**. A letter will be mailed to You stating NevadaCare's decision and the reason for the decision. The letter will tell You how You can appeal the decision if You are not satisfied. You must let NevadaCare know if You want to appeal the decision. (Emphasis added.) (*See* CR 13, Exh. 8 at 000038).

The District Court's determination is correct, as a plan must give discretionary authority to the administrator or fiduciary "in specific words" but *Firestone* does not require "magic words." *See e.g. Mattive*, 893 F. Supp. at 1565. The plan need only give the power to construe disputed terms or to resolve disputes over eligibility for benefits.*Id*. It has been held that a plan confers discretion when it "includes even one important discretionary element, and the power to apply that element is unambiguously retained by its administrator." *Bogue v. Ampex Corp.*, 976 F.2d 1319, 1325 (9th Cir. 1992).

Where the administrator is operating under a potential conflict of interests, a "heightened standard" is applied. The court in *Atwood* held that "this 'heightened standard' does not alter our traditional abuse of discretion review **in the absence of specific facts indicating that [administrator's] conflicting interest caused a serious breach of the plan administrator's fiduciary duty** to Atwood, the plan beneficiary." *Atwood*, 45 F.3d at 1322. (Emphasis added). The court held that it ultimately applies "a traditional abuse of discretion standard to the decisions of apparently conflicted employer- or insurer-fiduciaries unless the affected beneficiary comes forward

with further evidence indicating that the conflicting interest caused a breach of the administrator's fiduciary duty to the beneficiary" *Id.* at 1323.

It was held in this Circuit in *Lang v. Long-Term Disability Plan,* 125 F.3d 794 (9th Cir. 1997):

> . . . we must review the decisions of an apparently conflicted employer or insurer-fiduciary under the traditional abuse of discretion standard unless it appears that the conflict may have influenced the decision. To make such a showing, the **affected beneficiary must come forward with "material, probative evidence, beyond the mere fact of the apparent conflict, tending to show that the fiduciary's self interest caused a breach of the administrator's fiduciary obligations to the beneficiary.**" *Citing Atwood* (citations omitted). (Emphasis added).

Simkins has not come forward in any pleading with material and probative evidence required to establish that an actual conflict of interests of NevadaCare has improperly influenced its decision in this matter. *See Atwood,* 45 F.3d at 1323, *see also Zavora v. Paul Revere Life Ins. Co.,* 145 F.3d 1118 (9th Cir. 1998). Thus, the District Court's ruling on the record before it that the "abuse of discretion" standard is appropriate for review of NevadaCare's denial of coverage was correct. This Court should therefore affirm the decision reached in the District Court.

E. The Court must uphold NevadaCare's interpretation of the terms of the Plan, unless such interpretation is "abuse of discretion."

Although this Court reviews *de novo* the District Court's grant of summary judgment, NevadaCare's decision should only be reversed if it constitutes abuse of discretion. *Siles v. Ilgwu National Retirement Fund*, 783 F.2d 923, 926 (9th Cir. 1985).

It is well-established in this Circuit that "ERISA plan administrators 'abuse their discretion if they render decisions without any explanation, or construe provisions of the plan in a way that conflicts with the plain language of the plan.' " *Taft*, 9 F.3d 1469, 1472, *quoting Eley v. Boeing Co.*, 945 F.2d 276, 279 (9th Cir. 1991), *Johnson v. Trustees of W. Conference of Teamsters Pension Trust Fund*, 879 F.2d 651, 654 (9th Cir. 1989). Furthermore, it is an abuse of administrator's discretion to rely on clearly erroneous findings of fact in making benefit determinations. *Id.* at 1473, *quoting Oster v. Barco of Cal. Employees' Retirement Plan*, 869 F.2d 1215, 1218 (9th Cir. 1988) (no abuse of discretion by an ERISA administrator unless the decision is "so patently arbitrary and unreasonable as to lack foundation in factual basis").

No abuse of discretion took place in the instant case. NevadaCare informed Simkins of the reasons for its decision in the original letter of denial of coverage, which stated that the requested treatment was not a covered benefit because of a policy limitation. The letter further stated that the denial was not related to medical necessity. *See* CR9 at Exh. 2. ("The NevadaCare evidence of

coverage (EOC), which you received at the time of enrollment outlines the benefits of transplant services and specifically states that tissue transplant coverage is limited to allogenic bone marrow only.") NevadaCare relied on the representations of Simkins and her doctors as to the nature of the procedure for which coverage was requested. Based on such representations, it denied coverage for HDC/PSCR under a bone marrow transplant limitation. Such determination was not erroneous, rather, it was the only position rationally supported by the record before NevadaCare. Likewise, NevadaCare's interpretation of the plan terms is not in conflict with the Plan's plain language, as the Plan clearly limits the scope of covered treatments and does not include HDC/PSCR. Simkins never presented to NevadaCare, as alternative grounds for coverage, the argument that HDC/PSCR could be fragmented into allegedly covered treatments, and therefore should not be allowed to argue at this time that failure to consider such fragmentation was an abuse of discretion on behalf of NevadaCare.[7]

Simkins argues that the Plan is ambiguous and such ambiguity should be resolved against the insurer and drafter of the policy, NevadaCare, under doctrine known as *contra preferentem*. Such application of the doctrine has been expressly rejected in *Atwood*, where this Circuit held:

> Atwood argues that, because he interprets the plan to mean that his resignation followed a

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[7] For the reasons stated above, this Court should disregard any such fragmentation argument.

> substantial diminution in his duties or responsibilities and [the administrator] interprets the plan to mean the opposite, the plan must be ambiguous, and hence under contra preferentem, his interpretation should be accepted. **This application of the doctrine would completely do away with the abuse of discretion standard we must apply in reviewing [the administrator's] decision.** 45 F.3d at 1324. (Emphasis added).

Thus, this Court should reject Simkins' contention that the Plan should be interpreted against the drafter.

For the above reasons, this Court should find that no abuse of discretion took place in NevadaCare's decision to deny benefits to Simkins. The judgment of the District Court must be affirmed.

CONCLUSION

The pertinent terms of the Plan are not ambiguous, and NevadaCare did not abuse its discretion in handling of Simkins' claim. Thus, the District Court's grant of summary judgment in favor of NevadaCare should be affirmed. Likewise, District Court's denial of Simkins' motion for summary judgment should be affirmed.

DATED this 1st day of February, 2000.

By: /s/ Constance L. Akridge

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In The

Supreme Court of the United States

NEVADACARE, INC.,

Petitioner,

v.

RUBY SIMKINS and M & K ENTERPRISES,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

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PETITIONER'S BRIEF IN REPLY TO RESPONDENTS' OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

NevadaCare, Inc. ("NevadaCare") respectfully submits its brief in reply to the Opposition filed by the Respondents Ruby Simkins and M & K Enterprises ("Respondents") on March 1, 2001. Both of the questions posed by NevadaCare's petition meet the mandates of Supreme Court Rule 10: one is an important question of federal law that has not yet been addressed by this Court and the other seeks to resolve a conflict among the circuits on the application of *contra proferentem*.

REBUTTAL ARGUMENT

THIS COURT SHOULD RESOLVE THE DIFFERENCES AMONG CONGRESSIONAL ACTS OF EQUAL DIGNITY

According to the Bureau of Labor Statistics, nearly 75 percent of full-time employees participate in employer-sponsored health care plans. U.S. DEPARTMENT OF LABOR, BUREAU OF LABOR STATISTICS, BULLETIN 2517, EMPLOYEE BENEFITS IN MEDIUM AND LARGE PRIVATE ESTABLISHMENTS, 1997 (September 1999). The percentage of those employees whose plan includes health coverage by a health maintenance organization (HMO) has steadily risen from 17 percent in 1991 to 33 percent in 1997. *Id.* Thus, in the decades since their creation, HMOs have become a part of the ERISA landscape; their participation is not hypothetical or tenuous. The threat posed by the Ninth Circuit's decision in *Simkins*, pitting an HMO's duty to provide low-cost health care against ERISA's requirement for a

clear and concise plan description, is likewise very real and must be addressed.

Specifically, this Court should resolve the questions posed by the Ninth Circuit's interpretation of 29 U.S.C. § 1022(a): can an average person understand basic medical terminology, and can that average person's understanding of her treatment be used to create an ambiguity in otherwise unambiguous plan language?

Although the Respondents would like to bind this case to its facts, the effects of the *Simkins* decision are far reaching. This case has never been about Respondents misunderstanding what policy language NevadaCare used to deny Mrs. Simkins' claim.[1] The Ninth Circuit would have the "person of average intelligence" read her plan description in a vacuum, without any knowledge of her medical condition or treatment which she gained in consulting with her physicians. The suggestion that an average person would consider a serious and complex procedure such as HDC/PSCR to be a blood transfusion is unreasonable.

In *Schachner v. Blue Cross and Blue Shield of Ohio*, 77 F.3d 889, 896 (6th Cir. (Ohio) 1996), *cert. denied*, 519 U.S. 865, 117 S. Ct. 173, 136 L. Ed. 2d 114, 65 U.S.L.W. 3247

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[1] At the time M & K Enterprises sought coverage from NevadaCare, Mrs. Simkins did not know her cancer had returned. (Pet. p. 4.) Upon Dr. Glaspy's recommendation that she undergo HDC/PSCR, Mrs. Simkins' request for pre-approval was denied in a letter dated April 30, 1998 based on the plan's exclusion of all tissue transplants except allogenic bone marrow transplants. (Pet. p. 5.)

(1996), cited by Respondents, the Sixth Circuit reached a conclusion antithetical to *Simkins*:

> **That the insured and the insurer may disagree over whether a particular treatment or procedure falls within an insurance certificate's scope of coverage does not necessarily make the language of the certificate ambiguous.** It is often necessary for health insurers to use broad language in drafting insurance contracts. It would be impractical, if not impossible, to include an exhaustive list of the treatments and procedures covered by a general health insurance contract. The language is ambiguous only if, on its face, it admits of two different interpretations. **(Emphasis added.)**

Not only is this a question of national importance, it appears there is also a circuit split.[2]

Finally, the case of *Hendricks v. Central Reserve Life Insurance*, 39 F.3d 507 (4th Cir. (S.C.) 1994), also cited by

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[2] As set forth in the Petition at pps. 11-13, there is a split of authority on this issue. *Compare Masella v. Blue Cross Blue Shield of Conn.*, 936 F.2d 98 (2d Cir. 1991) (approving district court's allowance of medical testimony) and *Brewer v. Lincoln Nat'l Life Ins. Co.*, 921 F.2d 150 (8th Cir. 1990), *cert. denied*, 501 U.S. 1238, 111 S. Ct. 2872 (1991) (court must concentrate on a layperson's understanding of a condition). In *Schachner*, the Sixth Circuit remanded the issue of whether the plan participant's cardiac rehabilitation fell within the scope of coverage to the district court to receive further evidence. See also, *Hendricks v. Central Reserve Life Insurance*, 39 F.3d 507 (4th Cir. (S.C.) 1994) (appellate courts must defer to district court's evaluation of medical expert testimony). In the instant case, the Ninth Circuit admitted that the district court found that "the undisputed evidence" shows that HDC/PSCR is a tissue transplant. App. 12.

the Respondents, further demonstrates a split between circuits on the issue of unbundling complex procedures to find coverage in an ERISA plan. The *Hendricks* courts refused to fragment HDC/PSCR when the insurer's denial of coverage was based on an exclusion for experimental treatments. The question is then whether unbundling—a disallowed practice under Medicare—will be allowed under ERISA contingent upon the insurer's reasoning in denying the claim, i.e., a specific policy exclusion rather than experimental. While both *Simkins* and *Hendricks* dealt with HDC/PSCR, the application of the unbundling principle could reach common, everyday procedures excluded from plan coverage, but which are nonetheless the sum of various covered procedures (for example, radiology, administration of drugs, hospital stay).

THE ISSUE OF *CONTRA PROFERENTEM* IS RIPE FOR DETERMINATION BY THIS COURT

The application of *contra proferentem* in *Simkins*

Respondents' opposition alleges that the Ninth Circuit did not apply the *contra proferentem* rule in "reaching its decision that the district court erred in granting summary judgment in favor of the petitioner." (Resp't Opp'n p. 19.) However, Respondents admit that the Ninth Circuit applied this rule in entering summary judgment in favor of Simkins. (Resp't Opp'n p. 19 n.3.) This is in harmony with NevadaCare's Petition which states that the Ninth Circuit ruled that, "any jury hearing this case would be required to interpret any ambiguity in the favor of the insured, and, as such, directed the District Court to

enter summary judgment on behalf of the plaintiff." (Pet. p. 9.)

NevadaCare's Petition addresses not only those grounds on which the Ninth Circuit reversed the district court's decision, but also those grounds on which the Ninth Circuit relied on to mandate summary judgment be entered on behalf of Respondents. As such, the Petition asks this Court to settle the conflict among the circuits concerning *contra proferentem*, the contract interpretation principle employed by the Ninth Circuit to find that the district court was required to enter summary judgment in favor of Simkins.

The dispute among the circuits

In their opposition Respondents argue that this Court should not grant review on NevadaCare's *contra proferentem* question, asserting that the rule "is not an important matter for the highest court in the country to review." (Resp't Opp'n p. 18 n.2.) Additionally, Respondents argue that this Court has "consistently denied *certiorari* to cases determining the ambiguity/non-ambiguity of specific policy provisions within an ERISA policy[.]" (Resp't Opp'n p. 21.) Respondents' assertions ignore the national importance of uniform interpretation of policy language in ERISA plans.

Employment-based health insurance is "by far the most common source of health coverage in the United States" even at time when insurance costs are increasing. *Hearing on Health Insurance Coverage and Uninsured Americans before Senate Comm. on Health, Education, Labor and Pensions*, October 4, 2000 (statement of Paul Fronstin,

Ph.D. of the Employee Benefit Research Institute). Over 160 million Americans rely on privately sponsored employer health and welfare plans subject to the requirements of ERISA. Brief of Amicus Curiae of American Ass'n of Health Plans in Support of Petitioners, 1999 WL 1054919 at *5, *Pegram v. Herdrich*, 120 S. Ct. 2143, 143 L. Ed. 2d 164 (2000), *citing* Peter T. Kilborn, *Insurers Raise Health Coverage Costs to New Highs*, THE TOPEKA CAPITAL-JOURNAL, December 20, 1998.

However, currently there is little uniformity among the circuits as to the method to interpret the language of such policies. Under the current haphazard application of *contra proferentem*, the same policy may be interpreted differently in Nevada, Utah or Illinois as it would in Tennessee, Virginia or New York. This is certainly not the "federal common law of rights and obligations" contemplated by this Court in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987).

Americans view health insurance as the most important work benefit, and employment-based coverage is expected to expand. *Hearing on Health Insurance Coverage and Uninsured Americans*. From 1998 to 1999 alone, the percentage of small employers offering health insurance jumped from 54 to 67 percent. *Id.* The shear number of Americans participating in ERISA plans, both now and in the future, demonstrates that the method used by courts to interpret plan language is an issue of national importance. Therefore, this Court should grant NevadaCare's Petition and determine if *contra proferentem* is applicable to plans governed by ERISA, and if so, when it should be invoked and the extent to which it should be applied.

CONCLUSION

The *Simkins* decision, by rewriting not only the terms of the plan but also the history of the claim presentation and review, sets a dangerous precedent for the drafters of ERISA plan health insurance policies, and for the district courts which interpret them. This Court should grant review to NevadaCare's petition to create uniform standards for drafting and interpreting ERISA plans.

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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